ISDA Illinois School District Agency

ISDA STUDENT ACCIDENT CLAIMS ADMINISTRATOR

2023 STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to the ISDA Claims Administrator by the required due dates.

1. **Claim Form must be submitted no later than 90 days after the date of injury,**
2. **Itemized bills must be submitted no later than 90 days after the date of treatment, and**
3. **Explanation of Benefits (EOB) must be submitted no later than 180 days after the date oftreatment.**

Items #1, #2, and #3 must be submitted to the ISDA Claims Administrator if the Parent or Guardian has other insurance

INSTRUCTIONS **PLEASE RETAIN A COPY FOR YOUR FILES**

1. **The school official must complete PART A.**
2. **The Insured's Parent or Guardian must complete Part B.**
3. **In case of dental injury, the treating dentist must complete the Student Accident Dental Services Form (below).**

PART A - NOTICE OF INJURY FROM SCHOOL (Please PRINT)

Address of the School District (including city, state and zip code) _____

Name of School and School District _____

Name of School Official Reporting Injury _____ School Contact Phone _____

Name of Student _____ Name of Person supervising activity _____

Date of Injury _____ Time _____ AM/PM Name of additional witness, if any _____

The injury occurred while the student was participating in: **(please CHECK ANY THAT APPLIES)**

INTERSHOLASTIC SPORTS Football _____ **Game** _____ **Practice** _____ **Name of Sport** _____

ACTIVITY Travel to/from School _____ **Recess** _____ **Physical Education** _____ **Classroom** _____ **School Grounds** _____ **Other** _____

Please specify Other Activity _____

Part of the body injured _____ Right/Left side _____

Describe how injury happened (**Please BE SPECIFIC**):

_____

_____

Signature of School Official _____ Title _____ Date _____

PART B - STATEMENT FROM PARENT OR GUARDIAN (See Important Information on Second Page) **(Please PRINT)**

Name of Parent or Guardian _____

Home Address (including City, State and Zip Code) _____

Student's Date of Birth _____ Grade _____ Student's Social Security No. _____

THIS AREA MUST BE COMPLETED Is the student covered under any other insurance plan? Yes/No _____

Name of Employer _____ Name on Policy _____

Name of Insurance Company _____ Group/ Individual _____ Policy # _____

To facilitate submission of claim information, I authorize any physician, medical practitioner, hospital, clinic, medical or related facility, insurance company, other organization, or person that has any records or knowledge of the student's health, to give the records or information to the ISDA Claims Administrator, or its agents or representatives. A photocopy of this authorization shall be as valid as the original. This authorization is valid from the date signed for the duration of the claim.

_____ _____ _____

Date Print Name of Student Signature of Parent or Guardian

NOTICE: Anyone who knowingly misrepresents or falsifies material information requested in this Claim Form may invalidate coverage upon such finding.

STUDENT ACCIDENT CLAIM FORM

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A STUDENT ACCIDENT CLAIM

- **Complete the CLAIM FORM and send it to the ISDA Claims Administrator no later than 90 days after the date of injury by fax at (312) 930-7232.** If fax is not available to you, immediately after the student's injury, please send the CLAIM FORM to: ISDA Claims Administrator, Attn. Student Accident Claims, 333 W. Wacker Dr., Suite 1200, Chicago Illinois 60606.

- A school official must complete Part A of the Student Accident CLAIM FORM. **The parent or guardian must complete all sections in Part B of the CLAIM FORM - Statement from Parent or Guardian.**

- **DO NOT** leave this CLAIM FORM with the physician or hospital**. The Student Accident CLAIM FORM should be sent to the ISDA Claims Administrator immediately.**

- Students must be treated by a licensed medical or dental provider **within 30 days** after the date of the covered injury**.**

- Review the Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. The brochure is available at www.wcsit-isda.com/sa. An identification card is included in the brochure. **Please cut out the ID card and carry it with you. This ID Card should be presented to the hospital, Doctor and Dentist along with your primary insurance ID card (if applicable) whenever you seek medical or dental services for a school related injury.**

- Please remember that this plan is **EXCESS** to all other valid coverages. If you have other insurance, you **MUST** file a claim with your primary insurance carrier first even if you have a large deductible. Do not wait until you have all the bills or until the end of the treatment to avoid missing a due date.

- **Itemized bills** must be submitted to the ISDA Claims Administrator **no later than 90 days after the date of treatment. All bills must include the diagnosis and procedure codes.**

- When you receive the **Explanation of Benefits (EOB)** from your primary insurance carrier or claims administrator, send them to the ISDA Claims Administrator **no later than 180 days after the date of treatment**.

- All supporting documents should be sent within the required due dates by fax at (312) 930-7232, or to the following address: ISDA Claims Administrator, Attn. Student Accident Claims, 333 W. Wacker Dr., Suite 1200, Chicago Illinois 60606.

- For additional questions, please call (800) 419-3206 or (312) 930-6165**.**

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ISDA STUDENT ACCIDENT CLAIMS ADMINISTRATOR

STUDENT ACCIDENT DENTAL SERVICES FORM

TO BE FILLED OUT BY THE TREATING DENTIST

Date of Injury_____ If a Prosthesis is required, is this an initial placement?_____

Was the tooth/teeth sound prior to the current treatment? YES/NO _____

NAME OF DENTAL INSURANCE PLAN _____

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
			TOTAL FEE

_____ _____

Print Dentist's Name Dentist's Signature

_____

Street Address

_____

City State Zip

_____

Date

FEDERAL TAX ID NUMBER (REQUIRED FOR PROCESSING)