



2024-2025 K-12 ACCIDENT ONLY CLAIM FORM

Email, Fax or Mail Completed Form To:

Administrative Concepts, Inc.

PO Box 4000, Collegeville, PA 19426

Phone (800)-749-0154 / Fax (610)-293-9299 / claims@acitpa.com



Preferred Provider Network:

www.imsppo.com

(choose Student Athletic)

Account Management:

469-579-4139 Main

469-579-4482 Fax

CLAIM INSTRUCTIONS

- The accident form must be submitted within 90 days from the date of injury to Student Insurance Plans **BY THE PARENT OR GUARDIAN**
DO NOT WAIT FOR BILLS TO SUBMIT THE ACCIDENT FORM. DO NOT EXPECT THE PROVIDER TO FILE THIS FOR YOU.
- Treatment must commence within 90 days of injury. Treatment will be covered for 1 year from accident date.
- All payments will be made to the providers of service (Hospital, Physician and others), unless accompanied by a paid receipt.
- Mail all **ITEMIZED** bills showing diagnosis, dates of treatment and charges to Student Insurance Plans with any applicable Explanation of Benefits from the primary insurance carrier **within 90 days of treatment or payment by the primary insurance carrier**
- Full Excess coverage - **benefits are payable for covered expenses that are not payable by another Health Care Plan**
FAILURE TO FOLLOW PRIMARY CARRIER'S GUIDELINES WILL RESULT IN DENIAL OF BENEFITS
- Please note the name of the school DISTRICT on all bills and correspondence. NO ADDITIONAL CLAIM FORM IS NECESSARY.

For Verification of provider participation visit imsppo.com

NO CLAIM CAN BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

PART I - SCHOOL REPORT

1. School District		2. Name of School				
3. Student Name: Last	First	Middle	4. Students ID#	5. Grade	6. Birthdate	7. Sex
8. Nature of Injury (Please describe fully indicating what part of the body was injured – i.e. broken arm, sprained ankle, etc.) Left <input type="checkbox"/> Right <input type="checkbox"/>						
9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO AN ACCIDENT.						
10. If accident occurred at school or school sponsored activity, please complete the following: Yes <input type="checkbox"/> No <input type="checkbox"/> a) While claimant was supervised? Yes <input type="checkbox"/> No <input type="checkbox"/> b) During a sponsored activity?			11. a) Date & Time of Accident b) Place Occurred:		12. a) Name/Type of Activity b) Practice or Game	
13. Name and Title of School Official			14. Signature of School Official		15. Date	
16. School Official Email:				17. Phone Number:		

"Any person who knowingly and with intent to defraud any insurance company or any other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning fact material thereto, commits a fraudulent insurance act, which is a crime."

OTHER INFORMATION--MUST BE COMPLETED IN FULL

1. Name of Father or Guardian:	
2. Name of Mother or Guardian:	
3. Home Address:	3A. Phone Number:
(City, State, Zip Code)	
4. Parent Email Address:	
6. Is the student covered under any other insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Group or Individual? _____ If the coverage is Group, please provide the following information: Name of Insured: _____ Relationship to Student: _____ Insurance Company: _____ Phone # or Policy #: _____	
7. Is the student insured under CHIPS or Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws, as well as State laws I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Parent or Guardian **MUST BE SIGNED** Date Signed

ATTENTION PARENTS – it is your responsibility to file the claim form with Administrative Concepts, Inc. and to present this form to physicians and facilities in order to receive benefits. Failure to do so may result in requests for additional information and possible claim processing delays.

Dear Parents,

Should you have any questions, contact the claims office as indicated on the claim form. The school “IS NOT” responsible for your medical payment or bills your child incurs. All medical charges are “YOUR RESPONSIBILITY” if your child is injured during ANY Athletic or UIL Activity in Texas or during any school sponsored and supervised activity.

Your school may have purchased a supplemental policy to cover any charges in excess of your own insurance policy or you may have purchased a voluntary policy. If you have NO OTHER INSURANCE for your child, this policy will then pay first or primary. This policy has dollar maximums and benefit limitations. Any charges above the policy benefit limits are YOUR RESPONSIBILITY. This policy was purchased by the district based on funds available. Please be aware that this policy is not intended to cover all medical bills for your child.

How to File a Claim

1. Only one claim form for each accident needs to be submitted.
2. Your school has a specific benefit plan that is not a guarantee of benefits, but rather an explanation.
3. A school official must complete Part A for all school related accidents. The parent or guardian must complete all questions in Part B. If the accident is not school related, the parent or guardian may complete both Part A and Part B of the claim form. **NOTE:** This claim form or a copy of the claim form must be presented to the physician or facility in order to obtain benefits and the preferred provider discount.
4. Submit copies of all bills to your primary family and/or group insurance first, even if you have a large deductible or copay. This plan is supplemental to all other insurance coverage (Blue Cross, Group Health, Prudential Insurance, etc.).
5. Send copies of itemized bills. These are the original billings you receive, not monthly statements. These itemized bills often called UB-04 or CMS-1500 and must contain the provider address, date of service, procedure code, diagnosis code, and the provider's federal tax ID number and NPI number. Providers may submit itemized bills directly to the claim administrator at the address on the claim form.
6. After you have received payment or copies of “Explanation of Benefits” (EOBs) from your primary insurance plan- fax, email or mail the completed claim form, copies of student's itemized bills and other insurance EOBs to the address on the claim form.

Please keep a copy of the claim form for your records

**NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.
IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO SUBMIT THE CLAIM FORM AND ITEMIZED BILLS**

Preferred Provider Discounts – A list of preferred providers can be found at www.imsppo.com by choosing the Student Athletic Network. Benefits will be payable whether a preferred provider is utilized or not; however, costs may be reduced by selecting a participating preferred provider.