CLAIM NO.

OFFICE USE ONLY

PUPIL BENEFITS PLAN, INC.

Student Accident Insurance
101 Dutch Meadows Lane
Glenville, NY 12302
TELEPHONE (518) 377-5144
1-800-393-3301
FAX (518) 377-3291
www.pupilbenefits.com

MEDICAL CLAIM FORM

SCHOOL SECTION

1. The school authority shall complete the top portion of this claim form. **Please MAIL ORIGINAL claim form and print legibly.**
2. Give **original** form to the pupil or send to the parent, along with a parent information brochure. The parent must mail **original** form to us.

Please Print Legibly
School District (full name) ______________________________

School Contact ____________________ **Phone #** ____________ **Grade** ________

Student's Name ______________________________ **DOB** ____________

Date of Injury ___/___/___ **Bodily Part Injured** ____________ **Age** ________

[ ] Interscholastic Sport ____________ [ ] Game [ ] Practice [ ] Scrimmage
[ ] Non-Interscholastic ____________ [ ] Noon Hour Rec [ ] Intramural
[ ] School-Sponsored Activity ____________ [ ] Phys. Ed. [ ] Classroom [ ] Other

State exactly what student was doing and how the injury was sustained.

____
____
____
____

Was activity supervised by an employee of the district? [ ] Yes [ ] No

I certify that the above named student was enrolled in our district and verify the accident occurred as stated above.
Signature of principal or designated school authority ____________ **Date** ________

Parent:

Please attach your itemized bills (UB-92 &HCFA-1500) showing dates of service, with diagnostic & procedure codes on all charges. Balance due statements will not be accepted. Please attach primary insurance explanation of benefits or rejection notice for all charges if insurance is available.
PLEASE DO NOT LEAVE THIS FORM AT HOSPITAL OR DOCTORS OFFICE. THANK YOU.

Name of attending Physician ______________________________

Address ____________________ **Telephone** ____________

Tax ID ______________________________

MULTIPLAN
Call
1-800-546-3887
For
Network Referral

Pupil Benefits Plan, Inc. is primary to Medicaid and Child Health Plus.
Claims must be filed with us in a timely manner.

1-908-658-3535

PARENT SECTION

BENEFITS PAID ONLY IN EXCESS OF THOSE OF FAMILY and/or EMPLOYER POLICY(S).

TO FILE A CLAIM, USE THE FOLLOWING PROCEDURE:

1. Parent shall first complete the box below. Parent shall make claim under family and/or employer policy(s).
2. For charges in excess of payments under other policy(s) **submit by MAIL:**
   A. Completed **original** claim form-**Copies or faxes of original claim form are not acceptable.**
   B. Itemized bills
   C. Copy of explanation of benefits or rejection of benefits from primary insurance. –MEDICAL AND DENTAL (If accidental dental injury) .
   D. If no other coverage is available, comply with steps A & B.
3. **This claim must be submitted in a timely manner.**
4. **Expenses resulting from an accidental dental injury must be submitted to your medical coverage first for accidental dental. Remaining expenses should then be submitted to your dental coverage, if available.**
5. **Pupil Benefits Plan, Inc. is primary to Medicaid and Child Health Plus.**

ALL ITEMS MUST BE ANSWERED, DO NOT LEAVE BLANKS

(if not applicable, answer "none")

PLEASE PRINT LEGIBLY/ N/A IS NOT ACCEPTABLE

AS OF DATE OF INJURY:

Legal Names of Parents Or Guardians **(MOTHER)** ______ Phone ______
Address ______ City ______ State ______ Zip ______

(FATHER) ______ Phone ______
Address ______ City ______ State ______ Zip ______

Is this child insured under other insurance coverage? [ ] yes [ ] no Medicaid #
Child Health Plus # ______

Name of Insurance Carriers:
Medical #1 ______ **ID#** ______ **Phone#** ______
Medical #2 ______ **ID#** ______ **Phone#** ______

Dental ______ **ID#** ______ **Phone#** ______

Name and Address of Employers, At the time of the injury:
Father's Company ______

Address ______ City ______ State ______ Zip ______
Mother's Company ______

Address ______ City ______ State ______ Zip ______

I authorize Pupil Benefits Plan to issue benefits in connection with this claim directly to the doctor, hospital or any other person rendering services, and such payment shall release Pupil Benefits Plan from liability as to amounts so paid. [ ] Yes [ ] No

I hereby certify that I have read the answers to all parts of this form and attest that all information supplied is accurate and truthful.

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

SIGNATURE AND DATE REQUIRED:
Signature of Parent or Guardian X ______ **Date** ______

EXCLUSIONS: NO BENEFITS SHALL BE PROVIDED FOR:

1. Cosmetic surgery, (cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma) sickness, disease, orthodontia treatment.
2. Intentionally self inflicted injuries.
3. Injuries sustained during participation in a felony, riot or insurrection.

LIMITATIONS:

1. No benefits will be paid unless the first treatment has been provided within 90 days from the date of injury.
2. No benefits will be paid for treatment after 3 years have elapsed from the date of injury. (Except Open Dental)
3. Covered expenses are payable up to the maximum of policy in force; maximum aggregate dental benefits will be limited to $1000.00 when treatment extends over 12 months from the date of injury.

Pupil Benefits Plan, Inc. does not have relationships with any third party, affiliated or non-affiliated, where nonpublic financial or health information could be exchanged. Our privacy policy applies to all products and services. All information will be protected as required by law.