Student Accident Claims

Note to all parents with Philadelphia Accident Claim Form
Effective: July 1, 2023

All students within the Diocese of Jefferson City have access to a Student Accident Policy, underwritten by Philadelphia Insurance Company. This policy is a Full Excess Policy meaning if a student (Pre-K thru 12) is injured during school due to an accident it will pay covered medical expenses not covered by the student's primary health insurance.

- *The Diocese student accident policy pays only after your primary medical insurance has paid.*
- *These claims and subsequent payment are subject to limitations and exclusions, therefore payment is not guaranteed.*

For claims processing, Philadelphia provides an Excess coverage PPO card and a Claim Information Referral Sheet for parents to give to all physicians and/or facilities to bill as **SECOND PAYOR** on all claims. Philadelphia also requires a completed and signed claim form, with primary insurance information included.

By providing the providers and facilities with the Excess Coverage Card & giving Philadelphia with the primary insurance information, this should eliminate the need for parents to gather information on the claims and allows NAHGA Claims to handle all retrieval of documentation.

In order to keep any bills from being sent to collections, Winter-Dent recommends that you send all information within 90 days of the incident. This will ensure that NAHGA Claims can process all information in a timely manner.

Philadelphia will not pay claims without a claim form on file.

The claim form can be sent via mail, fax, email or can be dropped of at any of our offices.
Jefferson City - Columbia - St. Peters

Once we receive this information form you, we send it to Philadelphia for processing.
Please note that Winter-Dent does not process the student accident claims.

You may contact Mary Baysinger (573-634-2122, x1320, mary.baysinger@winter-dent.com) at Winter-Dent with any questions.
The Accident claim form and required documents can be sent to:

Mail:
Mary Baysinger
Winter-Dent & Co
PO Box 1046
Jefferson City, MO
65102

Drop Off:
ATTN: Mary Baysinger
101 E McCarty St
Jefferson City, MO
65109

Email: Mary.Baysinger@Winter-Dent.com
Fax: 573-636 -7500, Attn: Mary Baysinger

WINTER-DENT
100% EMPLOYEE OWNED COMPANY

NAHGA
CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

Diocese of Jefferson City

Referral Form

Diocese of Jefferson City maintains an accident insurance policy for all covered members injuries. This policy is excess to any other valid and collectible insurance – it is a secondary policy and all claims must be submitted to the member's primary insurance first.

1. Submit medical charges to any other insurance policy the patient is covered under first (regardless if the patient is the primary member or a dependent);

2. Once response is received, submit a valid HCFA-1500 or UB92/04, along with a copy of primary insurance Explanation of Benefits, directly to our claims administrator at:

NAHGA Claim Services
PO Box 189
Bridgton, Maine 04009-0189
Email: claims@nahga.com

Policy No.: PHPA110745

****Preferred method for submitting claims is through electronic submission and can be sent to NAHGA using Payer ID 67788** (please note primary insurance information is accepted through that electronic feed)**

3. Payment will be made directly to the medical provider, unless otherwise requested.

4. Providers with claims questions can be emailed to: customerservice@nahgaclaims.com

5. Providers can sign up for online claims viewing for status at: https://claims.nahga.com !

*Disclaimer: Claims submitted under the **Diocese of Jefferson City** coverage are subject to all policy limitations and exclusions. This instruction sheet is not a guarantee of payment, it is intended only to facilitate submission of claims. NAHGA maintains appropriate standards and procedures to prevent unauthorized access to Protected Health Information in compliance with HIPAA. Please contact them at (800) 952-4320 if you wish to view a complete copy of our Privacy Policy.*

Diocese of Jefferson City

Philadelphia Indemnity Insurance Company

Student Accident Excess Coverage

Provided By Winter-Dent & Company

Diocese of Jefferson City

Philadelphia Indemnity Insurance Company

Insured Student: _____

Effective date: July 1, 2023 Policy #: PHPA136015

Provider Inquiries:

Please visit: https://claims.nahga.com/

Electronic Data Interchange (EDI) # 67788

Policyholder, Claimant or Agent Inquiries:

Please email: customerservice@nahgaclaims.com or call: 800.952.4320

The purpose of this card is to provide billing and claim contact information only. It does not guarantee coverage or reimbursement. This policy will reimburse a claimant for eligible medical expenses that are not payable by the claimant's private healthcare plan, automobile insurance or workers compensation coverage.

PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

ACCIDENT CLAIM FORM

MAIL TO: Winter-Dent & Co.
Attn: Mary Baysinger
P O Box 1046
Jefferson City, MO 65102

Questions: Contact 800-769-3472, x 1320

INSTRUCTIONS *(SIGNATURE SECTION MUST BE COMPLETED AT THE BOTTOM OF ALL THREE PAGES)*

- All fields must be completed
- Part I – Must be completed by Policyholder
- Part II – Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
- Attach explanation of benefits, additional bills with record of payment or denial from primary insurance carrier.This does not apply if the accident policy provides primary coverage
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.
- For additional instructions about how to file a claim, please send an email to **mary.baysinger@winter–dent.com**

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I – POLICYHOLDER REPORT (Signature is required at the end of this section)

1. Policy Number: PHPA110745
2. Name of Policyholder: Diocese of Jefferson City
3. Policyholder Address: 2207 W Main Street
4. City: Jefferson City State: MO Zip: 65109-0914
5. Policyholder Contact: _____ Email: _____
   Phone: _____ Fax: _____
6. Last name of Claimant: _____ First name of Claimant: _____
7. Social Security Number: _____ Date of Birth: _____
8. Sex: ☐ Male ☐ Female
9. Grade (if applicable): _____ Check one (if applicable) ☐ Day School ☐ Boarding
10. Nature of injury: **(Describe, fully indicate what part of the body was injured – e.g. broken arm, sprained ankle) Must be a bodily injury due to accident.**

11. Describe how the accident occurred, provide all details.
    Attach a separate sheet, if necessary (include name of sport / activity)

12. Did the accident occur:
    a. During a Policyholder supervised / authorized activity? ☐ Yes ☐ No
    b. During a Policyholder sponsored activity? ☐ Yes ☐ No
    c. During scheduled Policyholder hours? ☐ Yes ☐ No
    d. While traveling to or from a Policyholder sponsored and supervised activity? ☐ Yes ☐ No
    e. Off Policyholder premises, at home, during the weekend, holiday or summer vacation? ☐ Yes ☐ No
13. Date of Accident: _____ Time of Accident: _____ ☐ A.M. ☐ P.M
    Place of Accident: _____
14. Name and title of person supervising activity: _____
    Was he or she a witness? ☐ Yes ☐ No

Signature of Authorized Policyholder Representative **Title** **Date**

PART II

(To Be Completed by Claimant or Parent / Guardian, if Claimant is a Minor)

1. Name of Claimant or Father / Guardian:_____
   Social Security Number:_____ Email Address:_____
2. Name of Mother or Guardian:_____
   Social Security Number:_____ Email Address:_____
3. Street address of Claimant or Claimant Parent/ Guardian:_____
   City:_____ State:_____ Zip:_____
   Telephone Number:_____
4. Father or Guardian's Insurance Company:_____
5. Mother or Guardian's Insurance Company:_____
6. Name and address of Claimant or Father / Guardian's employer, if a minor:
   Employer's Name:_____
   Employer's Mailing Address:_____
   City:_____ State:_____ Zip:_____
7. Name and address of Claimant or Mother / Guardian's employer, if a minor:
   Employer's Name:_____
   Employer's Mailing Address:_____
   City:_____ State:_____ Zip:_____
8. List all medical and dental policies under which the Claimant is insured:

Name of Policyholder	Type of Policy	Policy Number

9. Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If yes, please provide a copy of the insurance card (front and back).
   a. Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No
      If yes, name of PPO Organization:_____
   b. Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No
      If yes, name of HMO or organization:_____
   c. Medicare? ☐ Yes ☐ No
   d. Medicaid? ☐ Yes ☐ No

AFFIDAVIT

I verify that the statement on the other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to Philadelphia Indemnity Insurance Company, its employees and authorized agents for the purpose of validation and determining benefits payable. I further authorize any Philadelphia Indemnity Insurance Company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

PAYMENT AUTHORIZATION (Signature is required at the end of this section)

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

Claimant Signature (Parent or guardian, if the claimant is a minor) **Date**

CLAIM FORM FRAUD STATEMENTS (Signature is required at the end of this section)

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison or any combination thereof.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE and IDAHO: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: Any person who, knowing and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: 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.

MAINE, TENNESSEE, VIRGINIA, and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defrauds, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA and OREGON: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant Signature (Parent or guardian, if the claimant is a minor) _____ Date _____