Email, Fax or Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082
(800) 328-2739

USA H&W Network
Provider Selection
800-USA-3860

To receive fee discounts, use the services of a LONESTAR preferred physician or facility. The LONESTAR Network is part of the USAMCO provider network.

This plan is supplemental to all other insurance coverage. You must file a claim with your other insurance first.

PROOF OF CLAIM: *When Injury results in treatment by a Physician, complete this form and submit to Student Assurance Services, Inc. within 90 days from date of injury, not to exceed one year.*

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____

   School Address _____
   (City) (State) (Zip)

2. Name of Student _____ Grade _____

3. Date of Injury _____ ☐ AM ☐ PM

4. Under whose supervision? _____ Was he/she a witness? _____

5. The accident was incurred while the Insured was participating in:

1. INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Practice ☐ Travel to/from Sport/Activity
☐ Game/Event
What Sport/Activity? _____

2. NON-INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Travel to/from school ☐ Non-school activity
☐ In classroom ☐ Physical Education
☐ Other - Activity? _____
☐ On school grounds

6. Part of the body injured _____ ☐ Left side ☐ Right side

7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) Date (mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
See Attached Claims Filing Information

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____
   Date (mm/dd/yyyy)

Students Social Security # _____

Parents Name _____ Relationship to Insured _____

Mailing Address _____
(Street, Route, or Box) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No

   Name of Insurance Company _____

   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I warrant that all of the information provided is true, complete, and accurate.

_____ _____ _____
Date (mm/dd/yyyy) (Print Name of Student/Patient) (Signature of Parent or Guardian)

ATTENTION PARENTS

*******PARENTS "YOU'RE RESPONSIBLE"*******

Dear Parents,

Below are steps for completing the Claim Form. Should you have any questions, contact the School Trainer/Adminstrator or call the number listed on the claim form. The school "**IS NOT"** responsible for your medical payment or bills for your child. 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.

HOWEVER, the school may have purchased a supplemental policy to cover any charges in excess of your own insurance 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 by **NO MEANS** was it intended to cover all medical bills for your child. **Your child's treatments and medical charges are your responsibility.**

Please contact the school trainer or administrator before seeking medical treatment or services.

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one claim form for each accident needs to be submitted.
2. The claim form and benefit summary are available at our website: **www.sas-mn.com**. However, this is not a guarantee of benefits but only an explanation that is subject to all applicable terms, conditions, limitations and exclusions of the plan.
3. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. 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 the Lonestar Provider Discount.
4. 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 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 below.**
5. 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.). This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage.
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:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
FAX: (651) 439-0200
EMAIL: CLAIMS@SAS-MN.COM

Please keep a copy of the claim form for your records

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

PREFERRED PROVIDER DISCOUNT PROGRAM

Student Assurance Services, Inc. has contracted for fee discounts for services received from physicians and facilities participating in the LONESTAR network which is part of the USA Managed Care Organization Network (USAMCO). Please note that benefits are payable as described whether you use a LONESTAR preferred provider or not. However, it is to your advantage to use a LONESTAR preferred provider since your costs may be reduced. A directory of LONESTAR preferred physicians and facilities is available at the USAMCO Network website **www.usamco.com/lonestar**.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.