Mutual of Omaha

HSR
Health Special Risk, Inc.

P.O. Box 250649
Plano, Texas 75025-0649
Payer ID# 65449
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734

School District: _____

School Name: _____

Student ID #: _____

Policy Number: _____

1. Please fully complete this form
2. Attach itemized bills (UB04 or HCFA-1500 form)
3. Mail, Email or Fax to *HSR*

Email: K12claims@hsri.com

## PART I – POLICYHOLDER'S REPORT

| 1. Claimant's Name (injured/ill person) | 2. Social Security Number | 3. Gender ☐M ☐F | 4. Date of Birth | 5. E-Mail |
|---|---|---|---|---|
| | | | | |

| 6. Address of Injured Person | 7. Phone Number (include area code) |
|---|---|
| | |

| 8. Parent/Legal Guardian Name, Address, City, State & Zip | 9. Phone Number (include area code) |
|---|---|
| | |

| 10. Date of Accident/Illness | 11. Time of Accident ☐a.m. ☐p.m. | 12. Place where Accident Occurred | 13. Date of First Treatment |
|---|---|---|---|
| | | | |

| Dental Claims | 14. Indicate which Teeth were Involved in the Accident | 15. Describe Condition of Injured Teeth Prior to Accident: ☐Whole, Sound, and Natural ☐Filled ☐Capped ☐Artificial |
|---|---|---|
| | | |

16. Type of Injury (Indicate Part of Body Injured – e.g., broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

| 18. Which Best Describes the Activity: | | |
|---|---|---|
| ☐ Play or practice of interscholastic sports | ☐ During lunch hour | ☐ Athletic period |
| ☐ Not school related | ☐ In school bus | ☐ On school property during school hours |
| ☐ P.E. class | ☐ School sponsored field trip | ☐ School sponsored activity during school hours |
| | ☐ Traveling to/from school | ☐ ROTC activity |

| 19. Name of Person Supervising the Activity | 20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport? |
|---|---|
| | |

| Signature of Parent/Legal Guardian: | | Signature of School Official: | |
|---|---|---|---|
| X | Date: | X | Date: |

## PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.**
**IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**
**I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.**
**New York Fraud Warning Notice: 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 material 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.**

| Signature of Parent/Legal Guardian: | | Signature of Witness: | |
|---|---|---|---|
| X | Date: | X | Date: |

## PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

**I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)**

SIGNATURE _____ DATE _____

**I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.**

SIGNATURE _____ DATE _____

**By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.**

## FRAUD WARNING NOTICES

Any person who knowingly presents a false of fraudulent claim for payment of 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.

### STATE SPECIFIC PROVISIONS

| | |
|---|---|
| **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. |
| **Alaska** | A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. |
| **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**<br>**Louisiana** | 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 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| **Connecticut** | This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony. |
| **Delaware**<br>**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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree. |
| **Hawaii** | For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. |
| **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. |
| **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** | 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 denial of insurance benefits. |
| **Maryland** | Any person who knowingly and willfully presents a false or fraudulent claim for payment of<br>a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **Michigan**<br>**North Dakota**<br>**South Dakota** | Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties. |
| **Minnesota** | A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. |
| **Nevada** | Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty o f a criminal act punishable under state or federal law, or both and may be subject to civil penalties. |
| **New Hampshire** | Any person who, with a purpose to injure, defraud 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 RSA638:20 |
| **New Jersey** | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| **New Mexico** | 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 civil fines 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** | WARNING: 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. |
| **Oregon** | Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties. |
| **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. |
| **Rhode Island**<br>**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. |
| **Tennessee**<br>**Virginia**<br>**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 include imprisonment, fines and denial of insurance benefits. |
| **Texas** | 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. |
| **Utah** | Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only. |

**Listed below are important instructions and comments about filing a claim.**

## YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   **Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

## YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills. Please also provide all doctors/hospitals with **HSR's Payor ID# of 65449**.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.
   1. **Please note that an itemized bill is defined as a bill/claim form from the provider via a UBO4 or HCFA-1500 claim form. Submitting itemized bills in any other format will delay the claims process. Providers are familiar with this process, so please be sure to (1) contact the provider and share the details above and request that the provider submit outstanding balances directly to *HSR*; or (2) secure a copy of the UBO4 or HCFA 1500s provided to the primary insurer and submit a copy to *HSR* for consideration. (See attached examples of a UB04 or HCFA-1500 on next page.)**
4. Due to HIPAA Privacy laws ***HSR*** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim. ***HSR*** cannot pay your bills using only the Primary Insurance Carrier's EOB.

## EXCESS INSURANCE

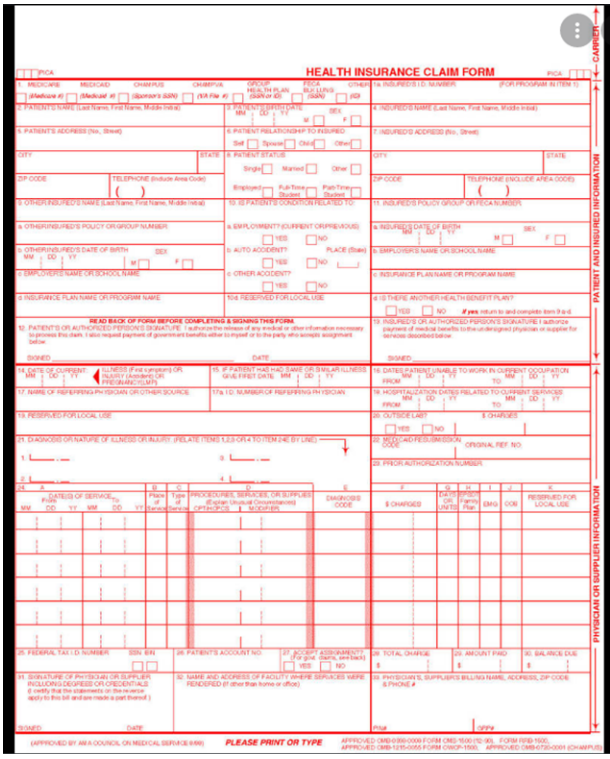
1. If the policy provides coverage on a secondary/excess basis and you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

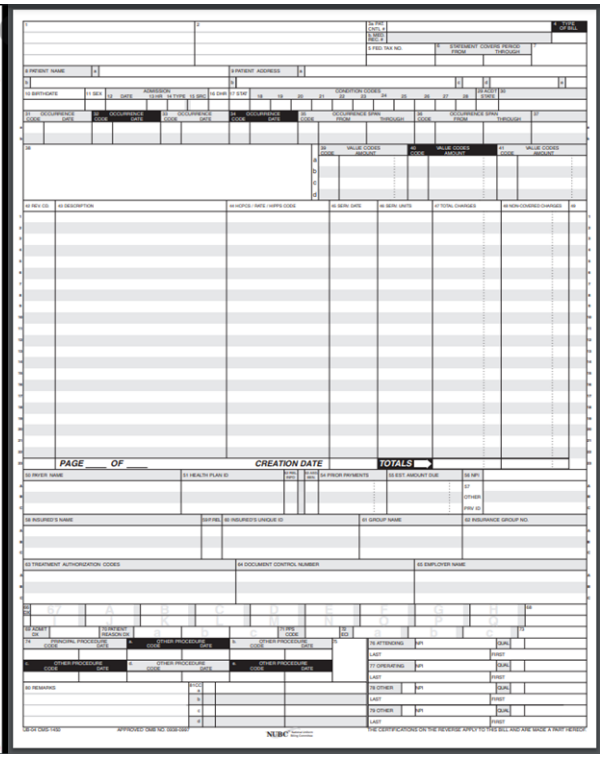
If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. to 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818 or email to K12claims@hsri.com.

***Health Special Risk, Inc.***
**P.O. Box 250649**
**Plano, Texas 75025-0649**

**What is an Itemized Bill?**

An itemized bill is a full detailed listing of all actual charges that a patient or their primary insurance is being billed for based on the care received. Typically, these come in the form of a HCFA-1500 for physician services or UB04 for facility charges. See below examples.




***Sample CMS HCFA Billing*** ***Sample UB04 Billing***