CLAIM FILING INSTRUCTIONS

** Upon accidental injury to an insured, a school representative should obtain the Notification of Injury Form from your School or Team Assure office. Only one form per injury is needed. To be a covered accident, injury must happen during an Association/school sponsored and supervised activity, treatment must commence within 30 days of injury by a legally qualified medical doctor, and Injury Form must be submitted within 90 days of the injury. There is a one year benefit period.

** A school representative (coach, principal, etc.) must **read the claim instructions** on top of the form.

** The school representative should complete Part I-School Report of the injury form answering every question, keep a copy and notify the parent or guardian to come and get the injury form. To protect the school and representative of the school have the parent/guardian sign and date line 14. when filling out the form. Give the parent or guardian of the injured student/athlete the partially completed Notification of Injury Form.

** Parent or guardian must **read the claim instructions** on top of the Notification of Injury Form. It is the parent/guardian's responsibility, not medical providers or school, to submit their form completed properly.

** Parent or guardian must understand that this is an **excess and secondary plan with a one(1) year** benefit period and that they should **first file on and follow procedures of any other individual or family medical plans(Private, All-Kids, Champus, Medicare, or Medicaid, etc.).** They should complete Part II of our plan's Notification of Injury Form, keep a copy, and send the injury form to the address on the top left of the form which is: **ABT Plan Administrator; P.O. Box 382048; Birmingham, AL 35238-2048.** Then send copies of itemized provider bills and corresponding explanation of benefits (EOB'S) from the other insurance plans when they arrive.

** **For claims submission straight to ABT our claims payer via the Ticket System: Go to our website at teamassure.net; look at the top of our webpage and scroll over the FORMS ICON, and click on CLAIMS SUBMISSION, then click on NEW SUPPORT TICKET and complete the information requested and attach any documentation you have received, (i.e., claims form, EOB's, billing statements, etc.). Then click on the SUBMIT BUTTON and your claim form and attachments will be submitted automatically to ABT for processing. This will be submitted straight to our claims payer, ABT, and is more secure than sending by fax or mail and has a quicker turn around in processing time for the claim.**

** **The parent, not a provider, must submit: the Injury Form, EOB's, and provider balance bills**

Please see Notification of Injury Form attached.

ORIGINAL

GAP PLAN
2016-2017 School Year

MAIL FORM TO:
ABT Plan Administrator
P.O. Box 382048
Birmingham, AL 35238-2048
1-888-283-3515

NOTIFICATION OF INJURY FORM

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

We must be notified when a student or student athlete is injured and has no major medical coverage so we can help them find Minimal Essential Major Medical coverage within the meaning of section 5000 A(f) under the Affordable Care Act.

FOR CLAIMS ADMINISTRATIVE USE ONLY

Policy Number
Reference Number
Coverage Code

- FULL EXCESS – Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance. You must submit your claim to all other insurance companies first. When you receive their Benefit Statement (EOB-explanation of benefits), send it to us, along with corresponding itemized bills. Benefits for eligible expenses will be paid per Benefit Plan terms.
- The claim form must be submitted within 90 days from the date of injury. Treatment must commence within 30 days from the date of injury by licensed medical doctor. Each injury has a one year benefit period.
- Note the name of the school district and Athletic Association on all bills and correspondence.

NO ADDITIONAL CLAIM FORM IS NECESSARY.

- Do not rely on the provider to file your claim for you. You are responsible for filing your claim form and all additional information.

PART I – SCHOOL REPORT

1. Name of School			2. School District and Athletic Association			
3. Name of Student - Last	First	Middle Initial	4. Social Security No.	5. Grade	6. Birthdate	7. Sex

8. Nature of injury (please describe fully, indicating what part of body was injured – e.g., broken arm, sprained ankle, etc.

9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO ACCIDENT.

10. Did Accident Occur:	Yes	No	11. a) Date of Accident	12. a) Name of Activity
a) While claimant was supervised	☐	☐		
b) During sponsored activity	☐	☐		
c) During programmed hours	☐	☐	b) Time	13. a) Name & Title of Supervisor
d) On activity premises	☐	☐		
e) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities	☐	☐	c) Place	14. Parent/Guardian acknowledgement of receipt Date: Initials:
15. Signature of School Representative			16. Title	17. Date

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETE IN FULL

PART II – TO BE COMPLETED BY CLAIMANT – OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian		2. Social Security Number	
3. Name of Mother or Guardian		4. Social Security Number	
5. Address of Parents or Guardian/or Claimant		5A. Telephone Number	
6A Father or Guardian's Insurance Company(ies)	6B. Mother or Guardian's Insurance Company(ies)	Check One:	☐ Individual ☐ Group
7A. Name, Address & Phone Number of Father or Guardian's Employer	7B. Name, Address & Phone Number of Mother or Guardian's Employer		

8. List other insurance policies under which claimant is insured	Policy No.		
1.	1A.		☐ Individual ☐ Group
2.	2A.		☐ Individual ☐ Group

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that I am required under Federal Law to purchase and maintain in force a Major Medical Health Plan that is compliant with the Affordable Care Act (ACA).

Signature of Parent or Guardian: _____ Date: _____

Authorization: I hereby authorize any physician or hospital that has treated or attended the above claimant to furnish the insurance company or its representatives any information requested. A photocopy of this authorization is to be considered valid.

_____ _____

Signature of Insured (Parent or Guardian if Insured is under 18) Date