



Texas Kids First

Providing affordable insurance to Texas Schools and school-age children

HOW TO REPORT A DISTRICT CLAIM

If a student is injured while participating in a UIL-sanctioned high school or middle school sport (practice, game and travel directly to and from) or other UIL-sanctioned activity that requires medical attention, notify the Athletic Trainer that the injury is a result of participation in a UIL-sanctioned activity prior to taking the injured student athlete to a health care provider. If the Athletic Trainer is not available, contact the head coach or athletic coordinator or teacher responsible for supervising the activity. If these persons are not sought out prior to visiting a health care provider, the District Plan may not pay any benefits. After seeking medical care, follow the procedures outlined below:

- Obtain a Student Accident Claim Form from a School Official.
- A coach, trainer, or teacher responsible for the activity must complete all parts of Section 1, and sign and date the form to certify that the accident is a covered activity under the District plan. Failure to have a school official complete Section 1 will result in the District plan not paying any benefits.
- A Parent/Guardian must complete all parts of Section 2, and sign and date the form.
- A copy of the completed and signed Claim Form should be kept by the parent/guardian and School Official to serve as verification of the injury.

******* FILE YOUR DISTRICT CLAIMS ELECTRONICALLY *******

- **The completed and signed Claim Form can be scanned and sent electronically to SAclaims@uflic.com to expedite payment of the claim as bills are submitted. The completed and signed Claim Form may also be mailed to the address indicated at the top of the Claim Form. Keep in mind that failure to submit a completed and signed claim form is the most frequent reason why claim payments are delayed.**
- Treatment by a licensed doctor and filing of a Claim Form must occur within 90 days from the date of the injury regardless of whether you have insurance or not.
- If you have other insurance, you must comply with the provisions of your primary insurance. File all bills with your primary insurance first and forward copies of itemized bills and EOBs to the Claim Administrator as you receive them indicating 1) the name of school district, 2) the name of the school, 3) the name of the injured student, and 4) the date of the accident.
- The plan purchased by the District is a limited benefit policy and may not cover all medical bills.
- Any charges not covered by the District plan are the responsibility of the Parent/Guardian.

ATTENTION PARENTS

Dear Parents,

Below are instructions for filing the Claim Form. Should you have any questions, contact the school trainer or call the number listed below. The school is **NOT** responsible for medical payment for your child. The school may have purchased a supplemental Accident Only Policy which may cover charges in excess of your own insurance policy. If you have no other insurance for your child, this policy may pay first or primary. This is a limited benefit policy and may not cover all medical bills for your child. Any charges not covered are **YOUR RESPONSIBILITY**.

For all school-related accidents, be sure to contact the school trainer or administrator.

INSTRUCTIONS FOR FILING THE CLAIM FORM

Section 1 must be completed by a school official for all school-related accidents and by the parent / guardian if 24-Hour coverage was purchased and the accident is not school-related.

Section 2 must be completed by the parent / guardian.

How to File A Claim

Step 1 - **Complete and submit the claim form to the Claims Office at the address indicated below or send electronically to SAclaims@uflic.com.** The claim form must be submitted within 90 days from the date of injury regardless of whether you have other insurance or not. Keep a copy of the claim form for your records and present a copy of the claim form to the provider or facility. **DO NOT RELY on the provider or facility to submit the claim form.**

Submit copies of itemized bills to the address indicated below. Itemized bills are original bills you receive, not monthly statements. Itemized bills are often called UB92 or HCFA1500 forms that provide the procedure code, diagnosis code, and the Providers' address and Tax ID Number.

Step 2 - **File a claim with your primary insurance first.** Submit copies of all bills to your primary insurance first. Your primary insurance is your family and/or group insurance coverage. The school's policy is supplemental to all other valid coverage.

Step 3. After receiving payment or copies of Explanation of Benefits (EOB) from your family and/or group insurance, **submit a copy of this claim form along with copies of your itemized bills and EOBs from your primary insurance company to the address below:**

**Fidelity Security Life Insurance Company
P.O. Box 304
Duncan, OK 73534-0304
(800) 366-8354**

Texas Kids First has unique access to one of the most creative innovations in the insurance industry – the Texas Kids First Provider Network (TKF Network)* – the first “no balance bill” non-profit network of providers in the State. The network consists of medical professionals and hospitals that have agreed to treat injured students from our insured districts for the services paid and outlined in the Schedule of Benefits of the Texas Kids First Student Accident Plans when the student patient has no other insurance.

Please refer to the website www.texaskidsfirst.com or call **1-800-366-8354** for a list of contracted providers in your area and to verify full assignment acceptance.

*The TKF Network is made available by Texas Kids First and is not affiliated with Fidelity Security Life Insurance Company.

FRAUDULENT CLAIM DISCLOSURE

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.



STUDENT ACCIDENT CLAIM FORM

SUBMIT CLAIM FORM TO: Fidelity Security Life Insurance Company
P.O. Box 304
Duncan, OK 73534-0304
(800) 366-8354

Section 1 - Notice of Injury (To be completed by School Official)		
(This section may be completed by parent if 24-Hour coverage was purchased and accident is not school-related)		
Name of School District: _____		
Name of School: _____	School Phone No: _____	
Name of Injured Student: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade: _____
Date of Injury: _____	Time of Injury: _____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Part of Body Injured: _____	<input type="checkbox"/> Right Side	<input type="checkbox"/> Left Side
Under whose supervision? _____		
Was accident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", by whom? _____		
The accident happened while the student was participating in:		
<input type="checkbox"/> Interscholastic UIL Activity <input type="checkbox"/> Non Interscholastic UIL Activity		
Specify Sport/Activity: _____		
Explain in detail how and where the injury occurred: _____		

Signature of School Official: _____		
	(Title)	(Date)

IMPORTANT INFORMATION ON REVERSE SIDE

Section 2 - Parent/Guardian Statement (To be completed by Parent/Guardian)		
Name of Student: _____	Date of Birth: _____	Home Phone No: _____
Is student covered by any insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Policy No. _____		
Parent/Guardian Name: _____		Relationship to Student: _____
Address: _____		
(Street)	(City)	(State) (Zip)
Father's Name: _____		Father's Employer: _____
Name of Father's Insurance Company (must be completed - If Father has no insurance - write "None"): _____		
Insurance Company: _____		Policy No. _____
Mother's Name: _____		Mother's Employer: _____
Name of Mother's Insurance Company (must be completed - If Mother has no insurance - write "None"): _____		
Name of Insurance Company: _____		Policy No. _____
I hereby authorize any insurance company, their authorized agent, hospital, physician, employer, school official 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, consultations, prescription or treatment, and copies of all hospital or medical records, and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that 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.		
_____	_____	_____
(Date)	(Print Name of Student)	(Signature of Parent/Guardian)