This Plan is a Limited Benefit Secondary Policy!

This plan may not pay 100% of the medical bills for an athletic injury, or even the balance after your primary insurance pays. It is Important to Have and/or Purchase Additional Coverage. Athletic injuries can lead to extensive medical treatment which can be very costly. Therefore, purchase additional insurance**. Alive Risk offers Voluntary Accident Insurance so request a brochure or go online to www.AliveRisk.com for additional details.**

KNOW YOUR COVERAGE - Two important aspects to this Athletic Accident Policy:

1. The benefit categories have maximum amounts that are paid out; and
2. This plan pays after any Primary Insurance the student may have.

How to File a Claim

To process your claim please submit the following three pieces of information:

1. Completed and Signed Claim Form
   a. Greenville County (***Policy # US1182265***)
2. Itemized Bills (Physician: HICFA-1500 and/or Hospital/Surgery: UB-04)
3. Explanation of Benefits (EOB's) from your Primary Insurance Carrier

INSTRUCTIONS:

1. **Coach/AD's Complete Claim Form**: Coaches and Athletic Directors are responsible for completing their portion of the claim form in the event of an injury.
2. **Parent Complete Remainder of Claim Form:** Once completed by school personnel, give the Claim Form to the student/parent to complete. Parents are responsible for completing the remainder of the Claim Form!
   a. The Claim Form enables us to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure the "other insurance" portion of the claim form is completed in full.
3. **Parent Submit Complete Claim Form:** Parents are responsible for submitting the completed claim form to A-G Administrators along with all other requested documents. Please go ahead and submit the Claim Form when complete even if you do not have the EOB's and/or Itemized Forms to go with it.
   Note: When taking your child to a doctor/heath care provider, please provide them with your personal family insurance information (primary), this letter, and a copy of the claim form. The parent should inform the provider(s) that they have Primary Insurance as well as Secondary Accident Insurance and request that they file to both.
   - Parent should request that the provider file to both primary and secondary insurance policies. If the provider is willing to file to both, it will save the parents a lot of time tracking down EOB's and HICFA-1500/UB-04 forms.
   - If the medical provider will not file to A-G Administrators directly, the parent will need to complete Step #4.

4. **Parent Submit Primary Insurance Explanation of Benefits (EOB's) and HICFA-1500/UB-04 Forms:** Submit the EOB's and Itemized Forms (HICFA-1500 and/or UB-04 forms) for services provided. Please submit with a copy of the claim form or write the Policy Number on all documents. The Policy # is: **US1182265**

    i. **Explanation of Benefits** from the Primary Insurance Carrier
        - If you have other medical insurance, all medical bills must be submitted to the primary medical insurance carrier first for their determination of eligibility. If the charges are not paid in full by the primary medical carrier we will need to see a copy of the "Explanation of Benefits" from that carrier prior to A-G Administrators issuing benefits.
        - If you have no primary medical insurance the need for an "Explanation of Benefits" will not be applicable to your claim.

    ii. **Itemized Forms** (Physician Visit: **HICFA-1500** Form and/or Hospital/Surgery:**UB-04 Form**)
        - Account statements or "balance due" statements are helpful, but **do not** contain all the information needed to process the charges.

5. *A claim cannot be process with bills/statements from the provider! They must receive the Itemized HICFA-1500 and/or UB-04 form (which contains the procedure codes) from either the provider filing secondary to A-G Administrators or the parent/student requesting and providing it to A-G Admin.*

These documents should be emailed, mailed or faxed to *(*Keep Copies of All Documents Submitted!):*

Email: thansen@agadm.com or Claims@agadm.com
Mail:
A-G Administrators, Inc.
Attn: Tyler Hansen/Claims Department
P.O. Box 979, Valley Forge, PA 19482
Fax: 610.933.4122
Phone: 610.933.0800
Toll Free: 800.634.8628

It takes 3-5 weeks to load and process claims and that is if they are provided complete and appropriate documents!! Therefore, it is very important to submit the requested documents as soon after the injury as possible. If A-G Administrators needs additional information, they will mail you a letter indicating what they need in order to process the claim. Please be on the lookout for correspondence from A-G Administrators.

To check the status of a claim:

A-G Administrators
Tyler Hansen
thansen@agadm.com
Phone: 610.933.0800
Policy (Greenville County): US1182265

If you have additional questions or issues that you cannot resolve through A-G Administrators, please call or email Gail Gray for Assistance:

McGriff Insurance Services – Gail Gray
Office: 864.672.1345
Email: Gail.Gray@McGriffInsurance.com

P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Special Risk Organization
Participant Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

Greenville County - Policy: US1182265

Special Risk Organization _____

Participant's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex ❑ M ❑ F SOCIAL SECURITY #

Cell Phone _____ Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ Accident Date _____

Body Part Injured _____ Place of Accident _____

Nature of Injury — Details of What Happened _____

INSURANCE INFORMATION

Does the claimant have primary insurance? ❑ Yes ❑ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on 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 A-G Administrators to the extent for which A-G Administrators 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 A-G Administrators and its designees.

PAYMENT AUTHORIZATION: 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.

_____ _____
PARTICIPANT SIGNATURE *(Parent or guardian, if participant is a minor)* Date

_____ _____ _____
SPECIAL RISK ORGANIZATION SIGNATURE Title Date

ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 1500 FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

Preguntas de reclamos: A-G Administrators, Inc.
Teléfono: 610.933.0800 • Fax: 610.933.4122
P.O. Box 979 • Valley Forge, PA 19482
www.agadministrators.com

INFORME DE LESIONES DEL ESTUDIANTE

Número de Póliza: US1182265

Nombre de La Escula: _____ # De la Ubicación/Nombre de la Escuela: _____

Dirección de la Escuela: _____ # De Teléfono de la Escuela: _____

Nombre del Estudiante: _____
PRIMER NOMBRE INICIAL DEL SEGUNDO NOMBRE APELLIDO

Fecha de Nacimiento: _____ Sexo: ☐ ☐ Número de Seguro Social del Estudiante: ☐☐☐☐☐☐☐☐☐ Grado del Estudiante: _____

Nombre del Padre: _____ Teléfono del Padre Durante el Día: _____

Dirección del Padre: _____
CALLE CIUDAD ESTADO ZIP (Código Postal)

INFORMACIÓN DE LA LESIÓN

Causa de la Lesión: _____ Hora/Fecha de la Lesión: _____

Parte del Cuerpo Lesionada: _____ Lugar de la Lesión: _____

Naturaleza de la Lesión — Detalles de lo que Pasó: _____

Sucedió el Accidente Mientras:

a. ¿Asistía a la escuela durante horas y días en que la escuela está en sesión? ☐ Sí ☐ No ¿En el hogar? ☐ Sí ☐ No

b. ¿Viajaba hacia o desde la escuela? ☐ Sí ☐ No Si es sí, ¿estaba el estudiante en la ruta regular y directa? ☐ Sí ☐ No

c. ¿Participaba en una actividad patrocinada y supervisada por la escuela? ☐ Sí ☐ No Nombre y lugar de la actividad: _____

d. ¿Estaba el estudiante participando en un deporte intraescolar? ☐ Sí ☐ No ¿Un deporte interescolástico? ☐ Sí ☐ No ¿Qué deporte? _____

Certificación del Distrito/Escuela Firma Requerida:

Yo, por medio de la presente, certifico que el estudiante está inscrito en la escuela y que la lesión fue sufrida bajo una supervisión adecuada mientras participaba en una actividad patrocinada por la escuela.

Cargo del Oficial del Distrito/Escuela **Firma del Oficial del Distrito/Escuela** **Fecha**

El Distrito Debe Llenar la Información Anterior

INFORMACIÓN DEL SEGURO (A SER LLENADA POR EL PADRE, MADRE O TUTOR LEGAL)

¿Tiene el padre, madre o tutor legal seguro de salud/médico? ☐ Sí ☐ No *(Adjunte una hoja separada si es necesario)*

Nombre y Dirección de la Compañía de Seguro: _____

Número de Póliza: _____ ID#: _____

Nombre y Dirección del Empleador de la Madre: _____

Nombre y Dirección del Empleador del Padre: _____

Firma de Certificación del Padre, Madre o Tutor Legal Requerida:

Yo autorizo a cualquier médico/hospital que haya atendido a mi hijo(a) para que divulgue la información así adquirida para el propósito de este pago de reclamo. Yo, por medio de la presente, certifico que las respuestas anteriores están completas, son ciertas y correctas a mi leal saber y entender.

Correo Electrónico del Padre: _____ **Teléfono en el Día:** _____

Firma del Padre, Madre o Tutor Legal

Nombre en Letras de Imprenta del Padre, Madre o Tutor Legal **Fecha**

Vea la Parte Posterior del Formulario

Para procesar su reclamo, por favor envíe la siguiente información tan pronto como sea posible:

1. El "Informe de lesiones del estudiante" completado y firmado.

2. Todas las facturas médicas detalladas, copias de todos los recibos y cualquier formulario de Explicación de Beneficios (EOB) que reciba de su compañía de seguro de salud/médico primario.

Nota: Todos los reclamos deben enviarse primero a su compañía de seguro de salud/médico primario para su pago. Una vez que las facturas hayan sido procesadas por su compañía de seguro de salud/médico primario, envíe dichas facturas médicas detalladas, EOB y copias de todos los recibos a A-G Administrators, Inc.

Las facturas médicas detalladas deben mostrar el nombre y la dirección del proveedor del servicio, la fecha de atención, el tipo de servicio y los cargos. *No se aceptarán estados de cuenta o "balances pendientes"*.

Todas las preguntas en el Informe de lesiones del estudiante deben ser respondidas, y las firmas del distrito/la escuela y los padres son obligatorias.

Puede enviar documentos por correo postal estadounidense, fax o correo electrónico:

A-G Administrators, Inc.
PO Box 979
Valley Forge, PA 19482

Fax: 610-933-4122

Correo electrónico: claims@agadm.com

Si tiene alguna pregunta, llame a A-G Administrators:

Teléfono: 610-933-0800
Teléfono gratuito: 800-634-8628

ADVERTENCIA CONTRA FRAUDE: Cualquier persona que a sabiendas presente un reclamo fraudulento o falso para el pago de una pérdida es culpable de un crimen y puede estar sujeto a multas y ser puesto en la prisión estatal.