STUDENT MEDICAL PAYMENT REPORTING PROCESS

FOR SCHOOL DISTRICT ONLY

To better serve our members we are recommending that you only utilize SET SEG's online claim form when a student pursues outside medical treatment AND their parents are seeking assistance with out of pocket medical bills. Following the steps below will ensure prompt and accurate payment of the claim.

STEP 1

Instruct the parent to submit the medical bill first to their own insurance carrier.

STEP 2

If out-of-pocket medical expenses are incurred after their insurance processes the bill:

- Have the parent complete the Medical Payment claim form and submit it to your business office with a copy of their bill and itemization sheet. This should not be submitted to any medical provider.

- Then, report the incident online to SET SEG and include the completed Medical Payment claim form and copies of the bill.

We encourage you to continue keeping internal records of all student injuries.

Should you have any questions implementing these changes, please feel free to contact:

CCMSI | 2455 Woodlake Circle | Okemos, MI 48864

Phone: (866) 204-0808 or (517) 347-2331

Fax: (517) 349-1835 | Email: pcclaims@ccmsi.com

MEDICAL PAYMENT CLAIM FORM

SECTION 1: CLAIMANT INFORMATION *Please print*

Claim #: ____________________________
(FOR OFFICE USE)

____
NAME OF INJURED PARTY

____
IF MINOR, INCLUDE PARENT/GUARDIAN NAME | PARENT/GUARDIAN PHONE # | PARENT/GUARDIAN EMAIL ADDRESS | PARENT/GUARDIAN SOCIAL SECURITY #

____
CHILD SOCIAL SECURITY # | GENDER | DATE OF BIRTH

____
ADDRESS | CITY | STATE | ZIP CODE

Exact date of injury: _______________/_______________/_______________ Time of day: _______________________ ❍ a.m. ❍ p.m

Where did injury occur (include district name and building): ____

____

Description of incident leading to injury: ____

____

Part of body injured: ____

Medical treatment sought? ❍ YES ❍ NO When: __________/__________/__________ to __________/__________/__________

Where? Name of treatment facility (list all): ____

____

Witnesses (please provide names and contact information of all witnesses if known): ______________________________

____

SECTION 2: INSURANCE INFORMATION

Is the injured party covered by any health care coverage (including coverage under parents/guardians plan)? ❍ YES ❍ NO

Is the injured party covered by MEDICAID? ❍ YES ❍ NO

Is the injured party covered under any MEDICARE coverage? ❍ YES ❍ NO

____
NAME OF HEALTH/DENTAL PLAN | MAILING ADDRESS | CITY | STATE | ZIP CODE

____
POLICY/CONTRACT # | GROUP # | GUARANTOR NAME

SECTION 3: MEDICAL AUTHORIZATION

MEDICAL AUTHORIZATION: I hereby state the above information is true and correct to the best of my knowledge. I authorize the release of______________________________ medical documentation and other information which may be in the possession of any insurer, medical provider, physician, hospital, ambulance service or nurse, to any representative of **SET SEG** regarding my injuries, medical history, and physical and mental condition both prior to and subsequent to the date of this authorization, regardless of lapse of time. Upon presentation of this authorization or a photocopy of the authorization, you are authorized to release a copy of my medical records to any representative of SET SEG for the purpose of investigating an insurance claim. SI understand that the information disclosed pursuant to this medical authorization may **NOT** be re-disclosed to another party without my written consent. **THIS IS NOT A RELEASE OF MY INSURANCE CLAIM**. The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Medical Authorization shall expire upon final resolution of my pending claim with SET SEG. I understand that I may revoke this Medical Authorization at any time by sending a written notice to my medical providers or to SET SEG.

____
SIGNATURE | DATE

PARENT/GUARDIAN:
Please return this completed form and copies of any out-of-pocket medical bills to your school district.
With questions, email CCMSI PC Claims Team at pcclaims@ccmsi.com.