SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Complete this form
2. Attach all bills
3. Mail to

myers • stevens & toohey & co., inc.
26101 marguerite parkway
mission viejo, california 92692-3203
(949) 348-0656 • fax (949) 348-2630

EXCHANGE STUDENT WORLDWIDE MEDICAL CLAIM FORM

PLEASE PRINT OR TYPE CLEARLY

PART A PATIENT INFORMATION

NAME OF INSURED PERSON — FIRST — MIDDLE — LAST | AGE | GRADE | ☐ FEMALE ☐ MALE

NAME OF SCHOOL | NAME OF SCHOOL DISTRICT | STUDENT I.D. # FROM I.D. CARD | DATE OF BIRTH MO / DAY / YR

ADDRESS OF SCHOOL | CITY | STATE | ZIP CODE

DATE OF INJURY OR ILLNESS MO / DAY / YR | **TIME OF INJURY** : A.M. / P.M. (CIRCLE ONE)

IF INJURY OCCURRED: PLEASE ✔ ONE ☐ PRACTICE ☐ GAME ☐ P.E. ☐ CLASSROOM ☐ TRAVEL ☐ AT HOME ☐ INTERSCHOLASTIC SPORT ☐ OTHER ☐ FIELD TRIP

TYPE OF SPORT (IF APPLICABLE)

DETAILS ON HOW THE INJURY OCCURRED. **PLEASE BE SPECIFIC** (NOTE: IF YOUR SCHOOL USES AN ACCIDENT REPORT FORM, PLEASE ATTACH A COPY OF THE REPORT ALSO).

WAS STUDENT PART IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP)

NATURE OF ILLNESS (IF APPLICABLE): | WHEN FIRST TREATED: | HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

NAME AND ADDRESS OF HOST FAMILY:

HOST FAMILY PHONE NUMBER:

PART B PARENT OR GUARDIAN STATEMENT

RELATIONSHIP TO INJURED ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ OTHER

IS THIS DEPENDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN? ☐ YES ☐ NO

NAME OF (FATHER OR MALE GUARDIAN) | S.S. # OF FATHER OR MALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR MALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME OF (MOTHER OR FEMALE GUARDIAN) | S.S. # OF MOTHER OR FEMALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH MOTHER OR FEMALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME, ADDRESS AND PHONE # OF INSURED'S FAMILY PHYSICIAN | CITY | STATE | ZIP CODE | PHONE #

HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE?
☐ YES ☐ NO IF YES, WHEN?

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.

I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

PARENT OR GUARDIAN SIGNATURE
X

RELATIONSHIP TO STUDENT | DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CLAIM FILING PROCEDURE:

1. Parent or Guardian complete PART A & B *in full*.
2. Have attending doctor attach physician/dentist statement.
3. After A & B have been completed in full, mail to our office within 90 days after the date of first treatment.
4. File all bills with your family health and/or accident carrier. This can include employees plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefits plans, or health maintenance organizations (HMO's).
5. After you have received a notice of payment, notice of denial or letter stating you have met your deductible from your other health and accident carrier, forward this statement and all itemized bills to the address below.
6. If you have any questions, please contact the office below.
7. **IMPORTANT: All parts must be completed <u>in full</u> or claim will not be processed.**

Plan Administrator:

myers | stevens | toohey

myers • stevens & toohey & co., inc.
26101 marguerite parkway
mission viejo, california 92692-3203

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Underwritten by: