



**GOODWIN & GRUBER AGENCY**

McKnight East, 300 McKnight Park Drive  
Pittsburgh, PA 15237  
Telephone 412/366-5080  
Fax 412/366-3360

**SCHOOL CLAIM PROCEDURE**

**SCHOOL YEAR 2008 – 2009**

**TOP SECTION  
FOR SCHOOL**

To be completed and **signed** by a school official.

**BOTTOM  
SECTION  
FOR PARENT**

**Important** – Must be completed in full and **signed** by parent or guardian, otherwise claim form will be returned.

**REVERSE  
SIDE**

It is not necessary to complete the reverse side if itemized bills are attached, except on dental claims.

**IMPORTANT**

**DO NOT** leave claim form at hospital. **Itemized bills** and **Explanation of Benefits** forms from your primary carrier are required. Attach both with the completed claim form and forward to our office at the above address.

**ADDITIONAL  
BILLS**

**DO NOT** complete a new claim form for additional bills. Please note the name of the School District on any additional bills you send to our office. All bills must be **itemized** and the **Explanation of Benefits** form must be included.

**PLEASE NOTE**

This is an **ACCIDENT POLICY**. Claims for sickness, disease, etc. will not be honored. **The athletic insurance is secondary to parents' insurance.**

**If parents have HMO coverage, HMO procedures MUST be followed. OUT OF NETWORK SERVICES WILL BE PAID AT 50% OF THE USUAL AND CUSTOMARY FEE SCHEDULE.**

**The original claim form must be submitted within 90 days from the date of injury.**

If you have any questions, please contact our office.

## SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills

**GOODWIN & GRUBER INC.**

300 McKNIGHT PARK DRIVE

PITTSBURGH, PA 15237-6534

(412) 366-5080

Name of School _____	Policy No. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> Student's Social Security Number								
School System _____	Name of Student _____									
Student covered: <input type="checkbox"/> Schooltime <input type="checkbox"/> 24 Hr. <input type="checkbox"/> Dental <input type="checkbox"/> All Sports <input type="checkbox"/> Football	Student's Birthdate _____ Grade _____									
Name and Address of Parent or Guardian _____										
1. Date of Accident _____	Time _____	<input type="checkbox"/> AM <input type="checkbox"/> PM	Phone _____							
2. COMPLETE details of accident _____										
3. Nature of Injury _____										
4. Did accident occur while:										
(a) Attending school during hours and days school in session? <input type="checkbox"/> No <input type="checkbox"/> Yes ; on Home premises? <input type="checkbox"/> No <input type="checkbox"/> Yes										
(b) Travelling to or from School? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, was student on usual and direct route? <input type="checkbox"/> No <input type="checkbox"/> Yes										
(c) Engaged in a school sponsored and supervised activity? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name and place of activity _____										
(d) Was student participating in an Intramural ( <input type="checkbox"/> Yes <input type="checkbox"/> No) or Interscholastic ( <input type="checkbox"/> Yes <input type="checkbox"/> No) sport? What sport? _____										
5. Names and addresses of attending physicians _____										
I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.										
SIGNATURE OF SCHOOL OFFICIAL _____		Title _____	Date _____							
<small>(Required on all claims except 24 hour coverage)</small>										
SIGNATURE OF PARENT OR GUARDIAN _____		Date _____								
<small>(Parent please complete reverse side of claim form)</small>										

**This Section Must Be Completed by Parent or Guardian**

IF BLUE CROSS (HOSPITALIZATION) GROUP # _____ CONTRACT # _____ SERVICE CODE # _____	IF BLUE SHIELD (PHYSICIAN'S CARE) GROUP # _____ CONTRACT # _____ SERVICE CODE # _____	
NAME AND ADDRESS OF MOTHER'S EMPLOYER _____		NAME AND ADDRESS OF FATHER'S EMPLOYER _____
DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF SO, NAME OF COMPANY _____	POLICY NUMBER _____
ADDRESS OF OTHER INSURANCE COMPANY NAMED ABOVE _____		TYPE OF PLAN FROM THIS COMPANY <input type="checkbox"/> Individual <input type="checkbox"/> Group

**AFFIDAVIT**

I verify that the above 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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the insurance company named on the reverse side of this form to the extent of any amount collectible.

**SIGN:** Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

If insured is hospital confined, please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim.

**AUTHORIZATION**

I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.

**SIGN:** Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Pennsylvania Residents:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**PHYSICIAN'S OR DENTIST'S REPORT** (Required on Dental Claims).

1. Nature of Injury

2. Date of First Treatment \_\_\_\_\_

3. Has patient ever had the same or similar condition?  No  Yes . If yes, state when and describe \_\_\_\_\_

4. Nature of Surgical Procedure, if any & procedure code \_\_\_\_\_

5. Dates of Treatment \_\_\_\_\_ Description \_\_\_\_\_ Charge \_\_\_\_\_

\_\_\_\_\_

**TOTAL**

6. Has patient been discharged from treatment?  No  Yes . If yes, give date \_\_\_\_\_

7. Was patient confined to hospital?  No  Yes . If yes, give name and address of hospital and dates confined \_\_\_\_\_

8. TO WHAT OTHER INSURANCE COMPANY HAVE YOU REPORTED THIS CLAIM? \_\_\_\_\_

Name

9. List below teeth involved and indicate on chart.

Address

**CO. USE ONLY**

10. Describe Condition of Injured Teeth Prior to Accident.

- 1. CARIOUS
- 2. FILLED
- 3. WHOLE
- 4. CAPPED OR ARTIFICIAL
- 5. SOUND AND NATURAL



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16



32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

**NOTICE OF A LEGAL REQUIREMENT**—Please insert your Tax Identification No. as required by Section 6041 of the Internal Revenue Code.  
CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

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PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PHYSICIAN'S NAME AND ADDRESS

Name

(Please print or type)

Address

**HOSPITAL REPORT**—Attach Itemized Hospital Bill, if Any.

**\*PLEASE ATTACH ITEMIZED BILLS\***