SISC
Self-Insured Schools of California
Schools Helping Schools

TO: Parent(s)/Guardian

SUBJECT: Student Accident Coverage Reporting and Claim Filing Procedure

Student Accident Coverage is SECONDARY to any other insurance which provides medical benefits to your child. SISC is primary to Medi-Cal and Tricare. A claim must be filed with your primary insurance carrier (e.g., Blue Cross, Blue Shield) at the same time you file a Student Accident Coverage claim. ***If you subscribe to an HMO (Health Maintenance Organization), you must use it.***

If you have primary insurance, a copy of the "Explanation of Benefits" (how your insurance has processed the claim) from your insurance carrier is needed to process the Student Accident Claim.

Note: Student Accident Coverage has a maximum benefit of $2,500.00 for services rendered as a result of bodily injury. Treatment must begin within 30 days of the injury and benefits are only payable for services rendered within one year of the date of the injury. Physical therapy and chiropractic services are subject to additional limitations. The completed SISC claim form must be submitted to SISC within one year (52 weeks) of the date of injury.

ALL SECTIONS NEED TO BE COMPLETED OR YOUR CLAIM WILL BE RETURNED.

1. Report accidental injury to appropriate school official immediately.

2. Have designated school employee complete and sign the school's section of the claim form.

3. The claim form **must be filled out completely**—all areas need the specific information which is requested and the parents/guardians need to sign all the appropriate spaces.

4. Give a copy of the completed claim form to all providers to be billed directly to SISC.

OR

5. Send the completed claim form along with itemized bills and Explanations of Benefits (EOBs) if applicable to:
   SISC - Student Accident Coverage - P.O. Box 1847 - Bakersfield, CA 93303-1847
   You can also fax the necessary documents to: **Fax No.: (661) 636-4418** or
   Email them to: sisc_pl@siscschools.org

For your personal records, please keep a copy of all submitted paperwork.

Please direct any questions you may have regarding Student Accident Coverage to (661) 636-4710.

RK
Enc.

PARA: Los Padres/Tutores

ASUNTO: Procedimiento para reportar accidentes escolares y presentar un reclamo.

La cobertura para Accidentes Escolares es SECUNDARIA a cualquier tipo de seguro médico privado que su hijo/a tenga. La cobertura SISC es solamente primaria a Medi-Cal y Tricare.
El reclamo se debe presentar a su seguro médico primario (por ejemplo, Blue Cross, Blue Shield), al tiempo que reporta el reclamo de Cobertura para accidentes escolares. ***Si usted pertenece a una Organización para Mantenimiento de la Salud (HMO), usted debe utilizar esa cobertura apropiadamente.***

Si usted tiene seguro médico primario, se necesita la copia del reporte de sus beneficios de salud de su seguro médico (reporte que explica como su seguro médico ha procesado su reclamo), para poder tramitar el reclamo de Cobertura Para Accidentes Escolares.

Nota: La cobertura para Accidentes Escolares tiene una indemnización máxima de $2,500.00 por servicios médicos prestados como resultado de una lesión corporal. La primera consulta médica debe realizarse en el transcurso de los primeros 30 días después del accidente. Solo se indemnizará por servicios médicos prestados dentro de un año a partir de la fecha del accidente. Los servicios de fisioterapia y tratamiento quiropráctico están sujetos a restricciones adicionales. El formulario de reclamación completo se debe enviar SISC dentro de un año (52 semanas) después de la fecha del accidente.

DEBEN LLENAR LA FORMA DE RECLAMO EN SU TOTALIDAD O LA FORMA SERA DEVUELTA.

1. Reporte inmediatamente lesiones accidentales al representante de la escuela que corresponda.

2. Pida que el representante designado por la escuela llene y firme la parte correspondiente a la escuela.

3. El Formulario de reclamación **debe llenarse completamente** -- todas las secciones deben tener la información específica requerida, y los padres o tutores del niño deben firmar en los espacios correspondientes.

4. Entregue una copia del formulario de reclamo a los proveedores de servicios médicos para que manden los cobros directamente a SISC.

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5. Envíe el formulario de reclamo completo junto con las facturas detalladas y la explicación de beneficios (si correspone) a:
   SISC- Student Accident Coverage, P.O. Box 1847, Bakersfield, CA 93303-1847.
   También puede enviar los documentos necesarios por fax o correo electrónico:
   Fax No.:(661) 636-4418 Email: sisc_pl@siscschools.org

Antes de enviar los documentos, es recomendable que haga copias para sus archivos personales.

Cualquier pregunta concerniente a la Cobertura Para Accidentes Escolares debe dirigirse a esta oficina llamando al número de teléfono (661) 636-4710.

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Claim # ______________

STUDENT ACCIDENT CLAIM FORM

(Grades Preschool through 12)

☐ Supplemental Coverage

Mail To: SISC Student Accident Claims,
P.O. Box 1847
Bakersfield, CA 93303-1847
Ph. (661) 636-4710 Fax: (661) 636-4418 Email: sisc_pl@siscschools.org

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity?	❑ Yes	❑ No
B. Supervised school activity?	❑ Yes	❑ No
C. Field trip activity?	❑ Yes	❑ No
D. Supervised off-campus activity?	❑ Yes	❑ No
E. Sponsored and supervised travel?	❑ Yes	❑ No
F. Supervised athletic practice/competition?	❑ Yes	❑ No

Sport____

Name and Title of Supervising School Authority:

Name ______________________________

Title ______________________________

Signature ______________________________

School District ______________________________

School Name ______________________________

STUDENT'S FULL NAME	MAILING ADDRESS	CITY	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	GRADE	SEX	TELEPHONE
			❑ M ❑ F	

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: ______________________ Time:__________ a.m. __________p.m.

3. When did the student first consult a physician for this condition? Date: ______________

Completed by____ Date ______________________

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S)

SISC Accident Coverage is secondary to your private health insurance.

1. Father/Guardian Name ________________________________ EMPLOYED: Yes_____ No_____

Employer ________________________________ Employer Telephone (   ) ______________

Individual and/or
Group Insurance Company ________________________________ Policy # ______________

SOCIAL SECURITY # ______________________________Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature______________________Date__________

I authorize payment of medical benefits to physician or supplier of service.

Signature______________________Date__________

2. Mother/Guardian Name________________________________ EMPLOYED: Yes_____ No_____

Employer ________________________________ Employer Telephone (   ) ______________

Individual and/or
Group Insurance Company ________________________________ Policy # ______________

SOCIAL SECURITY # ______________________________Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Signature______________________Date__________

I authorize payment of medical benefits to physician or supplier of service.

Signature______________________Date__________

IMPORTANT: All hospital and doctor bills must be itemized.

NOTICE TO PROVIDERS: A copy of this claim form needs to be attached to your bill.

Reclamo # ____________

FORMULARIO DE RECLAMACIÓN ACCIDENTE ESCOLAR

(Grados Preescolar - 12)

Enviar a: SISC Student Accident Claims
P.O. Box 1847
Bakersfield, CA 93303-1847
Ph (661) 636-4710 Fax (661) 636-4418 Email: sisc_pl@siscschools.org

☐ Cobertura Suplementaria

TO BE COMPLETED BY SCHOOL OFFICIAL – LO DEBE LLENAR UN FUNCIONARIO ESCOLAR

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity? ❑ Yes ❑ No
B. Supervised school activity? ❑ Yes ❑ No
C. Field trip activity? ❑ Yes ❑ No
D. Supervised off-campus activity? ❑ Yes ❑ No
E. Sponsored and supervised travel? ❑ Yes ❑ No
F. Supervised athletic practice/competition? ❑ Yes ❑ No

Sport ____________________

Name and Title of Supervising School Authority:

Name ____________________

Title ____________________

Signature ____________________

School District ____________________

School Name ____________________

STUDENT'S FULL NAME	MAILING ADDRESS	CITY	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	GRADE	SEX	TELEPHONE
			❑ M ❑ F	

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: ____________________ Time: __________ a.m. __________ p.m.

3. When did the student first consult a physician for this condition? Date: ____________________

Completed by ____________________ Date ____________________

TO BE COMPLETED BY PARENT(S) / GUARDIAN(S) – LO DE BE LLENAR PADRE / MADRE O TUTOR LEGAL

La cobertura SISC para accidentes escolares es suplemental a su seguro médico privado.

1. Nombre del padre/tutor ____________________ TRABAJA: Sí_____ No_____

Empleador ____________________ Número de teléfono de la compañía ____________________

Compañía de seguro
de plan Individual y/o de grupo ____________________ # de Póliza ____________________

de Seguro Social ____________________ ¿El menor tiene cobertura médica mediante este plan? Sí_____ No_____

Autorizo que se divulgue cualquier información necesaria para procesar este reclamo.

Firma ____________________ Fecha __________

Autorizo el pago de beneficios médicos para el médico o el suministrador de servicio.

Firma ____________________ Fecha __________

2. Nombre del madre/tutor ____________________ TRABAJA: Sí_____ No_____

Empleador ____________________ Número de teléfono de la compañía ____________________

Compañía de seguro
de plan Individual y/o de grupo ____________________ # de Póliza ____________________

de Seguro Social ____________________ ¿El menor tiene cobertura médica mediante este plan? Sí_____ No_____

Autorizo que se divulgue cualquier información necesaria para procesar este reclamo.

Firma ____________________ Fecha __________

Autorizo el pago de beneficios médicos para el médico o el suministrador de servicio.

Firma ____________________ Fecha __________

IMPORTANTE: Todas las facturas del hospital y el médico deben ser detalladas.
AVISO A LOS PROVEEDORES: Envíe una copia de este formulario al enviar las facturas médicas.