ADL RISK SERVICES, LLC

ACCIDENT MEDICAL CLAIM FILING INSTRUCTIONS

ADL Risk Services, ***Plan Administrator***
556 Clay Street Montgomery, AL 36104
Phone: 844.350.9897 **Secure Fax:** 334.649.7901
Email: Claims@ADLRS.com **Website:** http://adlrs.com

Please read these instructions fully, carefully and thoroughly prior to submission of any forms or claims in order to avoid a denial of your claim(s).

Form Submission Process & Eligibility Requirements

1) Complete ADL's **Student Accident Form** ("SAF") and submit to ADL Risk Services ("ADL") ***as soon as possible*** or **no later** than 90 days after the initial accident/injury date. (One SAF form per injury.)

   The most current form can be obtained from your school or are available on ADL's website. If you are not able to obtain your school's Plan ID# from your school's representative, please call ADL to obtain it. ***Part 1*** *of the SAF must be completed and signed by the designated school official as soon as possible after the injury occurs.* ***Parts 2 and 3*** *must be completed and signed by the student's parent or guardian. (If no insurance is available, state "no insurance" in the applicable field(s).) ALL fields must be accurately completed and must be signed and dated by the individuals, as indicated on the Form. Claims will be denied, if the SAF is not completed accurately and as indicated in the instructions. A copy of this form should be sent to ADL Risk Services, Inc.* ***as soon as possible*** *in order to open a claims file to process any incoming student accident medical claims. If the SAF is submitted after 90 days after the initial accident/injury date, YOUR CLAIM WILL BE DENIED. *The school and parent should also keep a copy for their own records.**

2) **Quick Claim Eligibility Criteria Checklist** (***ALL*** *are requirements in order for your claim to be eligible for reimbursement.*)
   - ☐ Accident/Injury occurred during school hours or while in attendance at a school associated/sponsored and supervised activity or event.
   - ☐ *Student Accident Form* accurately completed and submitted *as soon as possible*. (No later than 90 days after the initial injury date.)
   - ☐ Treatment for the injury/accident must begin within 30 days of the initial injury date by a licensed medical doctor, or your claim will be denied. (*Emergency Room treatment must occur within 72 hours of the injury in order to be eligible for reimbursement.)*
   - ☐ The treatments or services that are benefits eligible for reimbursement must have occurred (expenses incurred) within the 52-week (1 year) post-accident/injury benefit period. Any expenses incurred after the 52-week benefit period are not eligible for reimbursement/payment and will be denied.
   - ☐ Your primary insurance and any other available insurances must process the claim first prior to submission to ADL; otherwise, your claim will be denied. (**Exception: For Medicaid and Tricare, ADL should be billed as the Primary insurer.)*
   - ☐ All claims must be submitted/filed with ADL within 180 days of the end of the 52-week injury benefit period or they will be denied.
   - ☐ All required documents, forms, and receipts, as outlined in the **Claims Processing Instructions** section on page 2 of these instructions, have been completed or obtained for submission to ADL.
3) Provide all medical providers/facilities with ADL's billing address and contact information (at the top of this form) as your secondary/student accident excess medical insurance processor, and ask them to bill us directly once all other available insurances have been filed. (*See* ***Claims Processing Instructions*** *section on the following page, if the provider does not wish to file with ADL directly OR if the parent/guardian is seeking reimbursement for eligible out-of-pocket expenses.*)
4) **Read carefully** and follow the **Claims Processing Instructions** on the following page, as well as the additional information provided below.

Other Important Information

- This benefit plan is a student accident, full medical excess insurance plan, which means that benefits are provided after all valid and collectible insurances have processed the medical claim. It is not a major medical insurance plan and may not cover 100% of your out-of-pocket expenses, especially if you have not met your primary insurance's annual deductible or other out-of-pocket requirements.
- All submitted claims are subject to the Plan terms, conditions and benefits, as outlined in the coverage selected by the Planholder (your school or school district).
- *Dental Injuries:* This plan covers accidental injury to sound, natural teeth only. Primary dental and medical insurance should be filed first prior to filing with ADL, *with the exception* of Medicaid and Tricare.
- *Physical Therapy*: When related to rehabilitation after a surgical procedure, up to 25 visits are eligible for coverage. If visits are not surgical related, a maximum of 10 visits are eligible for coverage/reimbursement.
- *Concussion Visits:* A maximum of 3 visits are eligible for coverage/reimbursement.
- *Prescriptions/Medications:* Out-of-pocket costs that are not reimbursable by primary insurance for prescriptions prescribed by the medical provider overseeing the student's treatment may be eligible for reimbursement. An itemized pharmacy bill must be provided. Cash register receipts only are NOT acceptable.
- ***This student accident benefit plan does NOT cover COVID-19 related medical expenditures.***

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Claim Processing Instructions

The processes outlined below should be followed, if the remaining ***Claim Eligibility Criteria*** *(Page 1) have been completed.*

Who is filing for reimbursement?

Medical Provider/ Medical Facility

- This option is utilized when the medical provider or facility will be submitting/filing the claim directly to ADL for payment.
- The medical provider must be provided with ADL's Billing Information as your secondary student accident insurance provider in order to file the claim, AFTER your primary insurance has paid.
- The medical provider should submit completed claim form(s) (e.g., HCFA 1500, UB-04) with detailed information of the services and procedures with all applicable diagnosis, billing and service codes.
- In addition to the claim information above, primary insurance *Explanation of Benefits* ("EOB") must also be submitted to us.
- Any eligible payment(s) will be sent directly to the *medical provider* along with an updated EOB.
  A Denial will be issued for non-covered expenses or if any of the required documentation was not submitted or any of the eligibility criteria have not been met.

Parent/Responsible Party ***on behalf of*** Medical Provider/Facility

- This option should be utilized when a medical provider wishes not to file the claim with ADL directly or has "balanced billed" the parent/guardian after primary insurance has paid their portion.
- An itemized billing statement should be obtained from medical provider/facility and must be submitted to ADL (must detail diagnosis and service/procedures codes as well as line item charges). (*Note: 'Balance Due' statements are NOT an itemized billing statement and cannot be used for processing.*)
- In addition to the claim information above, primary insurance *Explanation of Benefits* ("EOB") must also be submitted to us.
- Any eligible payment(s) will be sent directly to the medical provider along with an updated EOB.
  A Denial will be issued for non-covered expenses or if any of the required eligibility criteria have not been met.

Parent/ Responsible Party

- This option should be utilized if the parent/guardian has paid for benefits eligible services or supplies out of pocket and wishes to be reimbursed directly.
- When applicable, an itemized billing statement should be obtained from the medical provider/facility and must be submitted to ADL (must detail diagnosis and service/procedures codes as well as line item charges). (*Note: 'Balance Due' statements are NOT itemized billing statement and cannot be used for processing.*)
- In addition to the claim information above, primary insurance *Explanation of Benefits* ("EOB") must also be submitted to us.
- Itemized/detailed supporting receipts (line item detail) or a patient statement *showing what and how much* was paid/is to be reimbursed must be submitted.

If you have any questions regarding eligibility or what is needed to process your claim after careful review of this document, please do not hesitate to contact us! Please have your claim information ready in order for us to provide you with prompt assistance!

Phone: 844.350.9897 **or Email:** *Claims@ADLRS.com*

ADL RISK SERVICES, LLC

Student Accident Form (SAF)

This form must be fully and accurately completed and submitted AS SOON AS POSSIBLE to ADL Risk Services (ADL) on or after the date of injury, and no later than 90 days from the initial date of injury, in order to avoid denial of your claims. *Please retain a copy for your records.*

Benefit eligible/covered expenses will be paid only when they are in excess of other valid and collectible insurances. ***Your medical provider must file your claim with all other available insurances prior to filing with ADL.***

Please provide all medical providers where treatment was/will be received with **ADL Risk Services'** billing address and contact information, as your secondary student accident medical insurance, to be billed directly once any applicable primary/other insurance has paid. ---------->

***IMPORTANT!** Please read the Accident Medical Claim Filing Instructions thoroughly and completely prior to submitting this form or filing any claims.**

NOTE: In order to avoid a denial of your claim(s), please ensure the above and following criteria are met.

Medical treatment must commence within 30 days of the initial injury date by a licensed medical doctor. (Or within 72 hours, if Emergency Room treatment is required.) Each injury has a one year (52 Week) benefit eligibility window. All claims must be filed as soon as possible, and no later than 180 days after the injury benefit period ends, or your claim(s) will be denied.

The Student Accident Plan Benefits are limited and may not provide 100% Coverage, especially if your primary insurances' annual out of pocket deductible or co-insurance requirements have not been met. This is a Student Accident Excess Benefit Plan, NOT a major medical health plan.

SUBMIT THIS FORM & CLAIMS TO:

Plan Administrator
ADL Risk Services, *LLC*
556 Clay Street
Montgomery, AL 36104
Phone: *844.350.9897*
Secure Fax: *334.649.7901*
Email: *Claims@adlrs.com*
Website: *http://adlrs.com*

PART 1: SCHOOL NOTIFICATION OF INJURY REPORT *(completed and signed by authorized school official)* Plan ID #: MS.11-11MSBASE-13

School District /Planholder: Greenville City SD, MS		School Name:	
Name of Student (First)	(Middle:)	(Last):	
Date of Birth: _____/_____/_____	Social Security No. (last four only):	☐ Male ☐ Female	Grade:
Date of Accident/Injury _____/_____/_____ Time: _____ Place: _____	Name of Activity or Sport Type: _____		Body Part Injured: _____ ☐ Left or ☐ Right side
At the time of the accident, was the student involved in an activity sponsored and supervised by the Planholder?			☐ Yes ☐ No
At the time of the accident, was the student traveling to or from a regularly scheduled school activity?			☐ Yes ☐ No
How did Injury occur?			
Name of School Official:		Was he/she a witness to the accident? ☐ Yes ☐ No	
Signature of School Representative: X_____	Title: _____	**Date:** _____/_____/_____	

Note: Part 1 above must be signed by an authorized school official, or claims will not be processed.

PART 2 : INSURANCE INFORMATION *(completed by parent/guardian)*

Is the Student covered by any other insurance Policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? ☐ Yes ☐ No

If Yes, Name of Insurance Carrier: _____ Is this ☐ Individual ☐ Group

Name of Policyholder: _____ Policy# _____

Is the above insurance a Medicaid Plan or other government insurance (such as TriCare?) ☐ Yes ☐ No

PART 3 : PARENT/GUARDIAN STATEMENT *(completed and signed by parent/guardian)*

Name of Father or Guardian (Please print legibly):		Name of Mother or Guardian (Please print legibly):	
Phone	Email	Phone	Email
Parent or Guardian Mailing Address (Include Street Address, City, State, Zip code):			
Is the above Parent/Guardian Employed? ☐ Yes ☐ No		Is the above Parent/Guardian Employed? ☐ Yes ☐ No	
Employer:		Employer:	

MEDICAL INFORMATION AUTHORIZATION & ASSIGNMENT OF BENEFITS: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization to furnish at the request of ADL Risk Services, LLC or the underwriting companies with which it works, information which you may possess including, findings and treatments rendered, and copies of all hospital and medical records for professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as valid and effective as the original. Payments will be made to the providers of service, unless a paid receipt/statement accompanies the medical claim submission. **Any person, who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony.**

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE: ____/____/____