SET SEG
School Insurance Specialists

MEDICAL PAYMENT CLAIM FORM

SECTION 1: CLAIMANT INFORMATION *Please print*

CLAIM NUMBER _____
(for office use)

NAME OF INJURED PARTY

IF MINOR, INCLUDE PARENT/GUARDIAN NAME

NAME OF SCHOOL DISTRICT

CONTACT NUMBER OR PARENT NUMBER

SOCIAL SECURITY NUMBER | 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 NUMBER | GROUP NUMBER | 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. I 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

Please return this completed form and copies of any out-of-pocket medical bills to your school district.
With questions, email PC Claims Team at pcclaims@setseg.org