

# ROCHESTER INSTITUTE OF TECHNOLOGY

## STUDENT EXCESS ACCIDENT INSURANCE CLAIM FILING PROCEDURE SHEET AETNA LIFE INSURANCE COMPANY

RIT maintains an excess accident policy for all students if medical expenses result from an on-campus accident or while the student is engaged in a RIT-sponsored activity off-campus. This policy has limits of \$10,000 provided under this policy per accident. Coverage is provided after all other primary medical insurance benefits on the student have been processed. (Benefits are governed by certain policy exclusions and limitations for certain types of accidents including NCAA intercollegiate sports injuries.)

Attached is a claim form for the Aetna Life Insurance Excess Accident Insurance policy. Please follow these steps for submission of your claim.

1. The claim form must be completed **in full**, signed and dated by the student or his/her authorized representative. It is necessary to provide a complete description of the accident, stating exactly what happened, where the accident occurred and the area of the body that was injured. The student's RIT ID **must be included** along with the Policy Number 812809-50-555 which is pre-printed on the claim form.
2. The RIT Student Excess Accident Insurance policy is a secondary payor policy. This means that medical expenses for **all** claims **must** be submitted to any other valid or collectible insurance carrier **first**. If unpaid balances remain, they may be submitted with the completed claim form, copies of the itemized bill(s) and Explanation of Benefits form(s) as provided from the primary insurer. These items should be mailed to Aetna Student Health P.O. Box 15708, Boston, MA 02215-0014. For questions, please call (800) 466-3185 - Voice or (800) 466-5996 - Hearing Impaired (TTY).

Note: If you were covered under the RIT Student Accident & Sickness Insurance Plan that plan will be the primary payor. The claims administration between RIT's Student Insurance plan and this Excess Accident plan will be seamless so you only need to submit the claim form once.

3. **Only one claim form for each accident is necessary.**
4. Bills for subsequent treatments for the same accident may be submitted without a claim form. Please identify your social security number and write "RIT" on the bill and indicate that the bill(s) is for service on a claim that had previously been submitted.
5. Itemized bills that indicate dates of treatment, the procedure code for type of service rendered, and charges for each service must be submitted in order for the claim to be processed. Receipts or balance bills that do not include the necessary itemization are not acceptable. Payment will be made directly to the provider of the service unless the bill is marked paid.
6. Claim service will be more efficient if the necessary information is provided at the time the claim is submitted. This will eliminate the need to write to the student, doctors, and others to access the necessary information. Should the insurance claims processor require more information, a detailed letter explaining what is further required to process the claim will be sent to the student.
7. An "Explanation of Benefits" (EOB) will be forwarded to you when the claim is processed. The EOB identifies amount of reimbursement for each service, an explanation of what is and what is not reimbursable and a copy of the check, if applicable, to the appropriate party is shown on the top of the form.
8. If you need assistance in completing the claim form, RIT's Student Insurance Plan Coordinator, Ms. Angie Shortino, is available to meet with you in the Student Health Center. You can arrange an appointment with her by calling her at 637-7660 (Rochester area) or by checking with the Student Health Center Office to learn her scheduled appointment times when she is on-site at the Student Health Center.

# CLAIM FORM

## Excess Accident Policy

Please return this form and any attachments to:

**Aetna Student Health.**

P.O. Box 15708

Boston, MA 02215-0014

(800) 466-3185

Hearing Impaired — (800) 466-5996

### Aetna Life Insurance Company

A fully completed Claim Form must be submitted with the first bill for every condition; non-completion of this form may result in delay or denial of your claim.

To be completed by student (Please Print)

<b>ROCHESTER INSTITUTE OF TECHNOLOGY</b>	<b>Excess Accident Policy #812809-50-555</b>
<b>STUDENT NAME</b>	<b>PATIENT NAME (IF DIFFERENT)</b>

Please check one:       Undergraduate       Graduate       Co-Op Student

<b>STUDENT UNIVERSITY ID NUMBER</b>	<b>PATIENT DATE OF BIRTH</b>
<b>ADDRESS</b>	<b>CITY</b>
<b>STATE</b>	<b>ZIP CODE</b>
<b>TELEPHONE NUMBER</b>	

IS PATIENT INSURED UNDER ANY OTHER INSURANCE PLAN <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, GIVE NAME AND ADDRESS OF COMPANY & POLICY NO.	IS PATIENT INSURED BY MEDICARE OR MEDICAID? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Effective date of other coverage: \_\_\_\_\_  
 Parents     Spouse     Other     Name of Insured: \_\_\_\_\_    Subscriber ID #: \_\_\_\_\_

**PLEASE SEND PAYMENT TO THE PROVIDER  ME  (PLEASE ATTACH PROOF OF PAYMENT)**

**SIGNATURE** \_\_\_\_\_

<b>COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM</b>	<b>COMPLETE THIS SECTION FOR A SICKNESS CLAIM</b>
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Exact nature of injury \_\_\_\_\_  
 Details: \_\_\_\_\_  
 How: \_\_\_\_\_  
 When: \_\_\_\_\_  
 Where: \_\_\_\_\_

Was injury due to practice or play of an NCAA sanctioned intercollegiate Sport? \_\_\_\_\_  
 Which sport? \_\_\_\_\_

**If sports related, please attach verification from athletic trainer**

Is condition work related?       Yes     No  
 Is condition due to an auto accident?       Yes     No

Date of sickness: \_\_\_\_\_  
 Date symptoms first noticed: \_\_\_\_\_  
 What is the exact nature of this sickness: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had the same or similar condition? \_\_\_\_\_  
 If yes, date of first treatment: \_\_\_\_\_  
 Date of last treatment: \_\_\_\_\_

Name and address of treating physician: \_\_\_\_\_

Were you treated in the RIT Student Health Center for this condition? \_\_\_\_\_  
 If your claim is for services outside of the RIT Student Health Center were you referred?       Yes     No  
 If not, why?       Away from school     Winter Break     Other

**AUTHORIZATION FOR MEDICAL INFORMATION**

**To all Physicians, Hospitals and other Health professionals:**

You are authorized to provide Chickering Claims Administrators, Inc. and any independent consulting health professional or auditor acting on its behalf or that of the insurance company information concerning health care, advise, treatment or supplies provided to the patient, including that relating to mental illness or substance abuse. This information will be used for evaluating and administering claims for benefits. This authorization is valid for the term of coverage. I agree that a photocopy is as valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (Claimant or Parent/ Guardian if Claimant is a minor)