

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 an 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 which is pre-printed on the claim form.
2. The RIT Student Excess Accident Insurance policy is a secondary payer 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. 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 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 RIT ID 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 the Student Health Center Office at 475-7949.



PLEASE RETURN THIS COMPLETED FORM AND RELATED BILLS TO:

Aetna Student Health, P.O. Box 15708 Boston, MA 02215
Or via fax to 860-907-4651

Please Note: All bills must first be submitted to any group hospital and/or medical plan to which you may be eligible. The primary Insurer's Explanation of Benefits indicating payments and/or denials must accompany this claim form.

Part 1

TO BE COMPLETED BY THE SUPERVISING OFFICIAL OF PARTICIPATING INSTITUTION

Last Name of Student		First Name	Middle Initial	Year in School	Student ID Number
Sport	Was student involved in school sponsored event: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury	Time of Injury	
Description of Injury (What happened, <u>how</u> and <u>where</u>)					
Sport designation: <input type="checkbox"/> Intramurals <input type="checkbox"/> Practice <input type="checkbox"/> Game <input type="checkbox"/> Other: (explain)					
I certify that all statements and answers on this form are true and complete, and that this claim satisfies all criteria set forth in our Accident Policy for proper consideration as a covered participant, covered activity and covered condition, to the best of my knowledge and belief.					
Name and Title of Supervising Official			Signature	Date	

Part 2

THIS SECTION TO BE COMPLETED BY THE STUDENT (PARENT OR GUARDIAN, IF MINOR)

Please note that this section needs to be filled out completely in order to contact the student in the event that additional information is needed to process the claim. Failure to complete this section completely will delay the processing of the claim.

Local address of Student		Student phone No.	Date of Birth (MM/DD/YY)
Name and Address of Parent or Guardian (Street, State and Zip)		Parent/Guardian Phone No.	
Student email address	Parent /Guardian email address		
Have you previously had any treatment for this particular injury or treatment to this area of your body? If "YES", please describe the circumstances include <u>how</u> , <u>when</u> , and <u>where</u> :			Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you entitled to benefits under any other insurance policy covering this injury? If "YES", please attach copies of statements of benefits paid or denied and complete the following:			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Insurance Company	Phone number	Effective date	
Name of Person Carrying Other Insurance Coverage:		Plan or Group Number	

Medical Information authorization/Assignment of Benefits/Authorization to Release Protected Health Information

I hereby authorize any licensed physician, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records, including any medical history of the above named person suffering loss, to furnish such information or copies of records to Aetna Student Health. A photographic copy of this authorization shall be as valid as the original. I can certify that the information given by me in support of this claim is valid and correct. Any person who knowingly and with intent to defraud any insurance company or other person files a 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. I also authorize Aetna Student Health to pay all bills in connection with the accident directly to the doctor, hospital or other rendering service. **I hereby authorize Aetna Life Insurance Company and their respective employees, agents and subcontractors, to provide copies of the Explanation of Benefits which contains protected health information to the supervising official/ participating institution identified in Part 1 section of this claim form. I understand that this authorization is voluntary. This authorization will be in effect for one year from the date signed.**

SIGNED _____
Injured Student (Parent or Guardian, if under 18)

DATE _____