

## ACCIDENT PROCEDURES

1. Provide first aid for the student sufficient to get the situation under control.
2. If the accident occurs on campus, campus police are notified.
3. If the accident occurs in the clinical area, faculty responsible for the course in which the student is injured must be notified immediately of the incident.
4. If it appears that a physician should see the student, he or she may chose to see his/her own physician, go to a minor emergency center, or be transported to a hospital. The student can pay the bill at the time of treatment or assign benefits and request reimbursement from ACC's insurance company.
5. The injured student will use the designated claim form. All components of the claim form must be completed as directed. The completed form must contain the signature of the student/claimant and submission of an itemized medical bill before reimbursement will be made. Reimbursement requests along with completed claim form should be sent to:
- 6.

**Austin Community College**  
**Risk Management Department**  
9101 Tuscany Way  
Austin, TX 78754  
Phone: 223-1015      Fax: 223-1035

7. The faculty or student submits a copy of the completed insurance form and HIPAA release form to the Assistant Dean of Health Sciences immediately after the incident.
8. The Faculty submits TWO copies of the Supervisor's Injury and Illness Analysis and Prevention Report within 48 hours of the event;
  - One copy to the Department Chair
  - One copy to the Assistant Dean of Health Sciences.
9. The Assistant Dean of Health Sciences will communicate the official notification of the claim to the Risk Management Department who confirms insurance coverage with the carrier and medical provider.

Forms are available on the web:

<http://www3.austincc.edu/it/eforms/frontpage.php?ID=RIIN.003>

[http://www3.austincc.edu/it/eforms/forms\\_int/RIIN.003/pdf](http://www3.austincc.edu/it/eforms/forms_int/RIIN.003/pdf)

<http://www.austin.edu/health/hsresource/>

Revised February 2011

### HIPAA Authorization for Use and Disclosure of Information

I hereby authorize the use and/or disclosure of my individual identifiable health information (the "information") as follows:

*Student "A"* In connection with the insurance claim on the accompanying Proof of Loss Form dated Print student name here (the "Claim"), I authorize my health care providers to disclose to Hartford Life Claims, my sponsoring College or University, and/or any insurance companies to whom the claim may be submitted (a "Payor"), all information related to the Claim, for the specific purposes of facilitating the processing and/or payment of the claim by Hartford Life Claims and communicating with Hartford Life Claims and the Payor about the claim.

This authorization is specifically limited to the individually identifiable health information related to the Claim.

I further understand and agree:

1. This authorization will expire upon the termination of the insurance policy between my sponsoring college or university and the Payor.
2. I may revoke this authorization at any time by notifying Hartford Life Claims in writing (although the revocation will not have any effect on any actions taken before receiving the revocation).
3. I may see and copy the information described on this form if I ask for it.
4. I am not required to sign this form in order to receive health care services from my provider.
5. The information that is used or disclosed under this authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

If I am signing this Authorization as a Claimant's Representative, I certify that I have the authority to act on behalf of the Claimant and that the information provided below to verify my identity is correct.

Student signs here *Student A*

Signature of Claimant or Claimant's Representative

2-16-2011

Date

Name of Claimant's Representative, if applicable:

Representative's Date of Birth:

Relationship to the Claimant:

Complete only if applicable.

**Do not send paperwork to this address. ACC Environmental Health & Safety will complete the documents with appropriate signatures and information and forward for payment.**

(For Special Risk, Sports, Campers, Youth Groups, and Tripster Policies)



Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy  
Please forward claims and questions to the following address:

Hartford Life Claims  
Blanket Lines Unit  
P.O. Box 3856  
Alpharetta, GA 30023  
Toll Free Number: (800) 678-6702  
Fax Number: (866) 954-3993

**Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail**

**The Policyholder (not the Parent, Claimant or Agent) should:**

- Fully answer/sign each item in the Policyholder Certification section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer/sign each item in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable).
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

**Step 2 - Submit itemized medical bills for payment consideration to our office. If the policy is Excess, (please consult with Policyholder or our office if you are unsure of this) also include any other insurance carrier's corresponding Explanation of Benefits (EOBs) as outlined in the helpful information bullet listed below.**

*Helpful information for submitting claims and expediting payment*

- A fully completed Notice of Claim is required for each accident/injury a Claimant incurs. Claims submitted with incomplete information will be denied pending receipt of the missing data.
- Release of claim forms by an insurance company is not an admission of coverage. In addition, information on the form is subject to audit by the insurance company.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

**A sample page is provided for you. Please complete the red boxed areas. ACC Environmental Health & Safety will complete the remaining boxes and file the claim.**



**HARTFORD LIFE & ACCIDENT INSURANCE COMPANY**

**Notice of Claim**

**THE HARTFORD**

FOR SPECIAL RISK, SPORTS, CAMPERS, YOUTH GROUPS & TRIPSTER POLICIES  
 Hartford Life Claims, P.O. Box 3856, Alpharetta, GA 30023 Toll Free (800) 678-6702 Fax (866) 954-3993

**POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official**

Policyholder Number	Agent Name	Agent Phone Number ( )
Policyholder Name		Policyholder Phone Number ( )
Policyholder Address (Street, City, State & Zip Code)		
Claimant (Injured Party) Name <b>Student A</b>	Date of Accident: (mm/dd/yyyy) <b>02-16-2011</b>	Time of Accident (hh:mm) <b>8:15</b> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM
Place of Accident <b>Hospital B</b>	Cause of Accident <b>Needlestick</b>	Indicate injured body part(s) <b>Rt. index finger</b>
Nature of sickness (if applicable)		Date sickness first commenced
<p><i>Policyholder Certification Signature Required:</i></p> <p>I hereby certify the Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have read and signed the Fraud Warning statement located on the reverse side of this form.</p> <p style="text-align: center;"><b>To Be Completed by ACC Environmental Health &amp; Safety</b></p>		
Title of Policyholder Official	Signature of Policyholder Official	Date

**CLAIMANT CERTIFICATION - To be completed by Parent/Guardian or Adult Claimant**

**New government regulations require Social Security Numbers for all claimants. Claims submitted without this will be returned.**

<b>Parent/Guardian completes for dependent child</b>		<b>Adult Claimant completes</b>	
Claimant (Dependent child) Name		Claimant Name <b>Student A</b>	
Claimant (Dependent child) Social Security Number		Claimant Social Security Number <b>000-00-0000</b>	
Claimant Date of Birth ( )	Daytime Phone Number ( )	Claimant Date of Birth <b>00/00/0000</b>	Daytime Phone Number <b>000 000-0000</b>
Claimant Address (Street Number, City, State, Zip)		Claimant Address (Street Number, City, State, Zip) <b>000 Street, Austin, Tx 00000</b>	
<p>Does the Claimant have medical coverage through?</p> <p>Mother's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Father's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Guardian's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicare policy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicaid policy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any other medical policy* <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>Do you have medical coverage through?</p> <p>Your employer* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spouse's employer* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicare policy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medicaid policy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any other medical policy* <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>*If yes and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.</p>		<p>*If yes and this Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.</p>	
<p><i>Parent/Guardian or Adult Claimant Certification Signature Required.</i></p> <p>I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician / hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.</p>			
<p><b>Student A</b></p> <p>Printed Name Parent/Guardian or Adult Claimant</p>		<p><b>02-16-2011</b></p> <p>Date</p>	
<p><b>Student A</b></p> <p>Signature of Parent/Guardian or Adult Claimant</p>			

**FRAUD WARNING CERTIFICATION - To be signed by Policyholder and Claimant (Based on State of residence)**

For residents of Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, D.C., Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files claim forms for insurance 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."

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction insurance benefits and may be subject to any civil penalties available.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

To Be completed by ACC Environmental Health & Safety Representative

Signature of Policyholder Official

Date

Student A

2-16-2011

Signature of Parent/Guardian or Adult Claimant

Date