



Plan Administered by:
A-G Administrators, Inc.
Attn: Claims Department
PO Box 21013
Eagan, MN 55121
Phone: 800-634-8628
Fax: 610-933-4122
Email: claims@agadm.com

Student Injury Medical Coverage Program Claim Reporting Procedures District/Parental Instructions

Please follow the procedures set forth below for filing a claim for student injury medical coverage. Claims will be handled in a prompt and efficient manner if the following steps are followed.

1. District/School must complete the top portion of the claim form. Once completed, the school will email/fax a copy of the partially completed form to A-G Administrators, Inc.
2. The District/School will return the original form to you (parent/guardian) and ask you to complete your portion. Please Note: Both the parent and District must sign the claim form.
3. **Parent/Guardian to process your claim, please submit the following pieces of information:**
 - Completed and signed "Student Injury Claim Form"
 - Itemized Bills (*samples of itemized bills are included on pages 3-5*) and Explanation of Benefits (EOBs) from Primary Insurance Company
 - All bills should be submitted to:

**A-G Administrators, Inc.
PO Box 21013
Eagan, MN 19482
Phone: 800-634-8628
Fax: 610-933-4122
Email: claims@agadm.com**

- If bills are processed by your primary health insurance carrier, please submit those itemized bills, explanation of benefits (EOBs) and receipts to A-G Administrators, Inc. for review.
- Bills: Please include copies of all medical bills incurred, showing the name and address of the provider of service, date of service, type of service and the charges. *Account statements or "balance due" statements are not accepted. Please see pages 3-5 for samples of the proper format for itemized bills.*

Important Information: A-G Administrators, Inc.'s insurance is excess, or secondary to, the parent or guardian's medical insurance/coverage. **All questions must be answered and requires district and parent signatures.**

Assuming that all information submitted is complete; you should anticipate a **decision** on your claim within 20-30 days. Please direct any questions that you may have regarding your child's claim to A-G Administrators, Inc. at **800-634-8628**.



ASCIP Student Injury Medical Coverage Program FAQs

Why is the student's school district providing student injury insurance?

Many health insurance plans have high deductibles and plan limits that leave parents with medical bills resulting from an unexpected student injury. This **excess** policy, provided by the district, protects students and families from the costs associated with school-time injuries.

Who is AG Administrators?

AG Administrators manages the student injury medical coverage program for the district. You will submit all claims to AG Administrators. AG will make sure to that all claims are complete.

Does primary insurance always have to pay first?

Yes. Medical claims must always be submitted initially to the primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess student injury policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

Does the student injury medical coverage pay for up front out-of-pocket expenses such as co-pays and deductibles?

Yes. These charges can be submitted to the student injury medical coverage policy to provide reimbursement for out-of-pocket expenses.

What documents are needed to process a claim?

The following documents are needed to properly process a claim:

- **Fully completed Student Injury claim form** available through the district's administrative office.
- **Itemized Bill - called Fifteen Hundred or UB form examples shown on pages 3-5**. This can be obtained through the provider. **DO NOT SEND** cash receipts, or past due statements for claims processing or payment. An **itemized bill as shown on pages 3-5** (Fifteen Hundred or UB form) contains the following information:
 - Provider's Name, Provider's Address, Tax ID Number
 - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
 - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** - you should receive a copy of this from your primary insurance carrier.

Where do I send all of these documents?

Please send all claim forms, itemized bills, primary EOBs, other insurance information and claims correspondence to AG Administrators:

PO Box 21013
Eagan, MN 55121
Phone: 800-634-8628
Fax: 610-933-4122
Email: claims@agadm.com

What insurance information do I have to give a provider?

When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your district/ schools student injury insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the **itemized bill** to AG Administrators. If you did not submit the secondary insurance information upon your first visit, please call the provider and submit the secondary insurance information to them. If the provider bills the school's student injury medical coverage directly, this will prevent a balance due statement from being sent to the student/parent.



ITEMIZED BILL FOR PHYSICIAN BILLING - HCFA 1500 FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ ☐ ☐ PICA										PICA ☐ ☐ ☐									
1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code) ()										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? ☐ YES ☐ NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										b. OTHER CLAIM ID (Designated by NUCC)									
SIGNED DATE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.									
15. OTHER DATE MM DD YY QUAL.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. 17b. NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										20. OUTSIDE LAB? ☐ YES ☐ NO \$ CHARGES									
A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										23. PRIOR AUTHORIZATION NUMBER									
F. \$ CHARGES G. DAYS OR UNITS H. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐										26. PATIENT'S ACCOUNT NO.									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO									
SIGNED DATE										28. TOTAL CHARGE \$									
32. SERVICE FACILITY LOCATION INFORMATION										29. AMOUNT PAID \$									
a. NPI b.										30. Rsvd for NUCC Use									
33. BILLING PROVIDER INFO & PH # ()																			
a. NPI b.																			

[illegible]

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																					
1. Type of Transaction (Mark all applicable boxes) ☐ Statement of Actual Services ☐ Request for Predetermination/Prauthorization ☐ EPSDT / Title XIX																					
2. Predetermination/Prauthorization Number																					
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																					
3. Company/Plan Name, Address, City, State, Zip Code																					
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																					
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)																					
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																					
6. Date of Birth (MM/DD/CCYY)				7. Gender ☐ M ☐ F		8. Policyholder/Subscriber ID (SSN or ID#)															
9. Plan/Group Number				10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other																	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																					
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																					
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																					
13. Date of Birth (MM/DD/CCYY)						14. Gender ☐ M ☐ F			15. Policyholder/Subscriber ID (SSN or ID#)												
16. Plan/Group Number						17. Employer Name															
PATIENT INFORMATION																					
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other														19. Reserved For Future Use							
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																					
21. Date of Birth (MM/DD/CCYY)						22. Gender ☐ M ☐ F			23. Patient ID/Account # (Assigned by Dentist)												
RECORD OF SERVICES PROVIDED																					
	24. Procedure Date (MM/DD/CCYY)				25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)				28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee					
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
33. Missing Teeth Information (Place an "X" on each missing tooth.)												34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = B; ICD-10 = AB)				31a. Other Fee(s)					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____					
35. Remarks																					
AUTHORIZATIONS																ANCILLARY CLAIM/TREATMENT INFORMATION					
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X _____ Patient/Guardian Signature Date																38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) ☐			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X _____ Subscriber Signature Date																40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)			
																42. Months of Treatment		43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)	
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident																46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)																TREATING DENTIST AND TREATMENT LOCATION INFORMATION					
48. Name, Address, City, State, Zip Code																53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X _____ Signed (Treating Dentist) Date					
49. NPI				50. License Number				51. SSN or TIN				54. NPI				55. License Number					
52. Phone Number () -				52a. Additional Provider ID				57. Phone Number () -				58. Additional Provider ID				56a. Provider Specialty Code					