NFHS Coaches and Officials Claim Information

To file a claim, please complete and sign/date the claim form. In addition, you will need to have it signed by the game assignor. Once the claim form is complete, submit it to:

Mutual of Omaha Risk Services
Claims Department
P.O. Box 31156
Omaha, NE 68131

or

specialrisk.claims@mutualofomaha.com

The NFHS accident medical insurance policy is an excess insurance policy. Excess insurance pays after your primary and any other secondary insurance pays. If you do not have any primary insurance, the NFHS plan will step in as primary up to the policy maximum. You will need to submit bills from your medical providers and any Explanation of Benefits (EOB) statements from your primary and any secondary insurance carriers, along with the claim form. Keep copies of everything you send for your records. If you incur additional expenses, submit those with a copy of your original claim form.

Please be advised that the NFHS insurance plan is subject to a $250 deductible. This deductible may be reduced by amounts paid by you or other insurance in conjunction with this injury.

Mutual of Omaha requires a claim be filed within 30 days of injury and initial treatment for injury sought within 90 days of the injury.

NFHS Coaches and Officials Claim Information

Summary of Benefits 2024-2025	
Blanket Accident Program	
Carrier	Mutual of Omaha
Effective Date	July 1, 2024 – July 1, 2025
Benefits	Excess Accident Medical Expense Benefit
Maximum Benefit	$50,000
Deductible (Disappearing)	$250
Accidental Death and Dismemberment Maximum Benefit	$10,000
Physical Therapy – per Visit	Up to $50 Per Day
Physical Therapy– Maximum per Injury	40 Days, Limited to One Treatment Per Day
Durable Medical Equipment – Maximum per Injury	Up To $1,000 per Covered Accident
Prescription Drug – Maximum per Injury	Up To $1,000 per Covered Accident
Benefit Period	52 Weeks
Concussion	Covered up to policy max of $50,000
Concussion Diagnosis	$100 cash benefit (5 per year)
Treatment by a Physician	Within 72 Hours

Covered Activities: Insured persons are covered for injury resulting from an accident that occurs directly from:

*Activities that are scheduled, sponsored, or supervised by the policyholder;
*Premises owned, leased, or borrowed by the policyholder;
*Travel scheduled, sponsored, or supervised by the policyholder; (accident medical coverage only)
*For officials/referees, coverage shall apply only while the member is engaging in officiating activities during regularly scheduled sports or activities competition, which includes assigning, chain crew, and attending or operating officiating camps, clinics, or meetings.

This Summary is for illustration only. For a complete list of all coverage, covered activities and exclusions please contact Dissinger Reed.

Dissinger Reed, a Division of HUB International
9200 Ward Parkway, Suite 500 - Kansas City, MO 64114
Phone: 800-386-9183 or 913-488-9449
Fax: 913-491-0527
Email: Justin.Vandewynkle@hubinternational.com
www.dissingerreed.com/nfhs

Tips for Filing a Claim – Participant Accident

- Mutual of Omaha Special Risk Services is a medical excess policy which considers charges secondary to any major medical policies. We'll need your major medical EOBs to consider any claims.

- Please make sure the claim form is filled out completely including an **official signature from the school/organization**.

- You can find the policy number on the claim form. Provide this to all the providers who render services. They will need to bill us directly as secondary insurance by fax (402-351-4732) or mail. We cannot accept balance due statements that providers mail to the patient. We need the actual billing forms shown below **UB04** (hospital bill) or **HCFA1500** (physician bill) that has **procedure, diagnosis, Tax ID** and **payment address** for the provider.

- If any out of pocket expenses are paid, please send us proof of payment. Our normal process is to pay your remaining balance to the provider, however, if we receive proof of payment we will reimburse the member.

- Each bill we receive will be assigned a claim number and once processed you will receive an **E**xplanation **o**f **B**enefits to show how the claim was processed/paid.

- Call 1-800-524-2324 if you have additional questions.

- Options for Sending Information:
  1. **Fax** 402-351-4732
  2. **Email**: specialrisk.claims@mutualofomaha.com
  3. **Mail**: Mutual of Omaha
PO Box 31156
Omaha, NE 68131

Claim Form

Complete and return this form to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324

*Only use black or blue when filling this form out

Section I Organization/School Information (required)

to be completed by organization or authorized official

Policy Effective Date July 1, 2024

Policy Expiration Date July 1, 2025

Policy Number SR2014IN-P-054461

Claim being filed is a:

☒ Noncatastrophic claim
☐ Catastrophic claim

Name of Policyholder National Federation of State High School Associations
(First) (Last)

Address of Policyholder 690 West Washington Street (Street) Indianapolis (City) IN (State) 46206 (ZIP Code)

Phone Number ______________________ Email ______________________

Verify that accident occurred during an activity sponsored or sanctioned by the policyholder, and whether claimant was a member at the time of the accident.

☐ Yes – Sponsored/Sanctioned activity
☐ Yes – Claimant was active member on date of accident

Under whose supervision? ______________________

Was he/she a witness? ☐ Yes ☐ No

I certify that the following information is true and correct.

Authorized Signature ______________________

Title ______________________ Date ______________________

Section II Claim Details (required)

completed by claimant, parent or guardian

Name of team/sport ______________________

Date of accident ______________________ Time of accident __________ ☐ a.m. ☐ p.m.

Location of accident ______________________

Type of activity ______________________

Accident occurred during: ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Interscholastic/Intercollegiate Sport ☐ Intramural Sport ☐ Other ______________________

Describe accident ______________________

Body part injured ______________________

Firsttreatment date ______________________

Dates claimed ______________________

Type of benefits claimed: ☐ Accident-Medical ☐ Dental ☐ Sickness-Medical ☐ Loss of Time

Section III Injured Party (Claimant) Information (required)

Name____
(First) (Last)

Address____
(Street) (City) (State) (ZIP Code)

Phone Number ____________________________________

Date of birth ____________________________________ Age________ ☐ Male ☐ Female

Claimant is a: ☐ Player ☐ Coach ☐ Official ☐ Other__________________________

Name of family physician ____

Address____

PhoneNumber ____________________________ Email ____________________________

Has treatment been completed? ☐ Yes ☐ No

Section IV Statement of Other Insurance (required)

completed by claimant, parent or guardian

Father/Guardian Name ____
(First) (Last)

Address____
(Street) (City) (State) (ZIP Code)

Phone Number ____________________________ Email ____________________________

Employer____

Employer Phone Number ____________________________ ☐ Self-Employed ☐ Unemployed

Mother/Guardian Name ____
(First) (Last)

Address____
(Street) (City) (State) (ZIP Code)

Phone Number ____________________________ Email ____________________________

Employer____

Employer Phone Number ____________________________ ☐ Self-Employed ☐ Unemployed

Is Claimant covered under any other medical and/or dental insurance policy? ☐ Yes ☐ No

Is Claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐ Yes ☐ No

Important Notice: This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with an itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

Details of Other Insurance Coverage (required)
completed by claimant, parent or guardian

Insured Name____________________ I.D. Number__________
(First) (Last)

Address____________________
(Street) (City) (State) (ZIP Code)

Insured Group Number/Name ____________________

Company Name ____________________

Address____________________
(Street) (City) (State) (ZIP Code)

Phone Number ____________________ Email ____________________

**Please include copy of insurance card (both sides)

Note: If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party:

Responsible Party Name ____________________
(First) (Last)

Address____________________
(Street) (City) (State) (ZIP Code)

Phone Number ____________________ Email ____________________

Section V Statement of Certification (required)
completed by claimant, parent or guardian

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: 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. (PURSUANT TO 11 NYC RR86)

Signature of Parent/
Guardian/Claimant (required) ____________________ Date __________

Section VI Authorization to Release Information (required)
completed by claimant, parent or guardian

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent/
Guardian/Claimant (required) ____________________ Date __________

Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **Arkansas, Louisiana and Rhode Island:** 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.

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

** **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.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

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

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** 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 subjects such person to criminal and civil penalties.

** **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 [be] 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.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a 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.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.