PA Program Accident Claim Procedures – step-by step guide

1. File the claim with your personal insurance company as the primary insurance and First Agency as your secondary insurance. (DO NOT FILE AS WORKER'S COMP). Do not pay any fees or copays because First Agency should pay those as your secondary insurance. If you went ahead and paid any fees, you should be reimbursed through First Agency.

   File as secondary insurance: **First Agency, Inc.**
   5071 West H Avenue
   Kalamazoo, MI 49009-8501
   Phone (269) 381-6630
   Fax (269) 381-3055

2. Fill out the *Student Accident Claim form.*
3. Fill out the *Authorization – To Permit Use and Disclosure of Health Information.*
4. Fill out the *Parent/Guardian/Student Information form*.
5. Fill out the *Incident Form*.
6. Make a copy of front and back of the insurance card.
7. Collect all bills associated with the injury that have not been paid. Attach all ITEMIZED bills (itemized bills include the date of service, procedure code, diagnosis code, etc. not balance due statements) for MEDICAL EXPENSES ONLY. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge must be processed by all other insurances/plans before they can be processed by First Agency, Inc.)
8. Collect a UB-04 or HCFA billing statement concerning the injury from the billing office of the facility.
9. Return all these things via fax (423-869-6460), e-mail (savanna.norrod@lmunet.edu) or mail to Ms. Savanna Norrod ASAP. Ms. Norrod phone number is 865-338-5685, if you should have any questions.

**If you receive any future bills from this incident, please send to Ms. Norrod as well, and she will forward all paperwork to First Agency insurance company.*

Physician Assistant Program
Department of Clinical Education
Policy on Needle Stick and Blood Borne Pathogen Exposure

Detailed information on the prevention of and treatment of exposure to blood borne pathogens is contained in the CDC brochure, "Exposure to Blood: What Healthcare Personnel Need to Know". Students should familiarize themselves with this information. http://stacks.cdc.gov/view/cdc/6853/

If a student experiences a needle stick, sharps injuries or is otherwise exposed to the blood of a patient while on clinical rotation, the student should:

Immediately perform basic first aid. Wash needle sticks and cuts with soap and water. Flush splashes to the nose, mouth or skin with water. If exposure is to the eyes, flush eyes with water, normal saline solution, or sterile irrigates for several minutes.

Immediately report the incident to the attending physician/preceptor. Prompt reporting is essential. In some cases, post exposure treatment may be recommended and should be started as soon as possible. If there is potential exposure to HIV, it is imperative to initiate prophylactic treatment within two hours of the incident. Also, without prompt reporting, the source patient may be released before testing for infectious disease can be conducted.

Seek post-exposure services. The student should follow this policy. If in an office, contact the Site Coordinator for instructions on how to fulfill these requirements. If in a hospital, contact the nursing supervisor or employee health service. All clinical sites will have a policy in place for blood borne pathogens, with a point of contact. This point of contact can help you follow the correct procedures. If it is after hours or if the student cannot locate a person to guide them, they should go immediately to the emergency department and identify themselves as a student who has just sustained an exposure.

Obtain baseline laboratory tests, if indicated. The treating clinician should evaluate the type and severity of exposure and counsel the student on the risk of transmission of HIV, HBV, and HCV. This may involve testing the student's blood and that of the source patient and initiating post-exposure treatment.

Complete the LMU Incident Report (attached). **The student should report the incident to the Director of Clinical Education and complete the LMU Incident Report within 24 hours of the exposure. The training site may require the student to complete a separate incident report for their facility.**

It is extremely important that students report incidents promptly to LMU-SMS to avoid problems that may occur later with payment for post-exposure treatment.

Costs incurred: Most training sites provide post-exposure treatment to students free of charge. If there are charges for services, the student must file all medical claims to their personal medical insurance first, then to the LMU intercollegiate policy.

NAME OF SCHOOL: Lincoln Memorial University

ADDRESS: 6965 Cumberland Gap Parkway, Harrogate, TN 37752

STUDENT ACCIDENT CLAIM FORM

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501
Phone: (269) 381-6630
Fax: (269) 381-30

STUDENT'S FULL NAME (PRINT) LAST _____ FIRST M.I.

STUDENT'S SCHOOL ADDRESS _____

STUDENT'S HOME ADDRESS _____

S.S.# _____ DATE OF BIRTH _____ SEX_____ GRADE _____

DATE OF ACCIDENT _____ HOUR_____ ☐ A.M. ☐ P.M.

DETAILED DESCRIPTION OF ACCIDENT: HOW DID IT OCCUR? (OR ATTACH ACCIDENT REPORT COMPLETED BY THE SCHOOL REPRESENTATIVE WHO WITNESSED THE ACCIDENT) _____

_____

_____

WHERE DID IT OCCUR? _____

PART OF BODY INJURED _____ ☐ RIGHT ☐ LEFT

ACTIVITY SPORT _____ ☐ INTERCOLLEGIATE ☐ INTRAMURAL

STUDENT ACCIDENT (describe) _____

HAS A CLAIM EVER BEEN FILED ON THIS STUDENT? ☐YES ☐NO

NAME OF SCHOOL AUTHORITY SUPERVISING ACTIVITY _____

WAS SUPERVISOR A WITNESS TO THE ACCIDENT? ☐YES ☐NO

IF NOT, WHEN WAS THE ACCIDENT FIRST REPORTED TO A SCHOOL AUTHORITY? DATE _____

SIGNATURE OF SCHOOL OFFICIAL _____ TITLE _____

DATE OF THIS REPORT _____

IMPORTANT: PLEASE ATTACH ITEMIZED BILLS
THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL MEDICAL BILLS INCURRED TO DATE.

HOW TO FILE YOUR **ACCIDENT** CLAIM FORM

1. Complete **ALL** blanks.

2. Please read and sign authorization on back of this form.

3. Attach all **ITEMIZED** bills (itemized bills include the date of service, procedure code, diagnosis code, etc. not balance due statements) for **MEDICAL EXPENSES ONLY**. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge ***must*** be processed by all other insurances/plans before they can be processed by First Agency, Inc.)

4. Mail within 90 days of the accident to:

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

First Agency, Inc., 5071 West H Avenue, Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request. This

Authorization is valid from the date signed for the duration of the claim.

(Please Print) Name of Claimant _____ Signature of Claimant if claimant is 18 or older _____ Date _____

(Please Print) Name of Authorized Representative, or Next of Kin _____

Relationship of Authorized Representative or Next of Kin to Claimant _____

Signature of Authorized Representative or Next of Kin _____ Date _____

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PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO →

Name of College/University **Lincoln Memorial University**
Attention _____
Address **6965 Cumberland Gap Parkway**
City **Harrogate** State **TN** Zip **37752**

This form is to be completed by the Parents, Guardians, or Student

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____
Social Security No or Passport No _____ Date of Birth _____
College Address _____ Cell Phone ( )
Home Address _____ Home Phone ( )
City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name
Date of Birth
Address

Employer
Address

Telephone ( )

Medical Insurance Company or Plan
Address

Policy Number
Telephone ( )

Is this plan an HMO or PPO? ☐Yes ☐No
Is pre-authorization required to obtain treatment? ☐Yes ☐No
Is a second opinion required before surgery? ☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Mother's Name
Date of Birth
Address

Employer
Address

Telephone ( )

Medical Insurance Company or Plan
Address

Policy Number
Telephone ( )

Is this plan an HMO or PPO? ☐ Yes ☐ No
Is pre-authorization required to obtain treatment? ☐ Yes ☐ No
Is a second opinion required before surgery? ☐ Yes ☐ No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

_____ _____

Name of Claimant (please print) Name of Authorized Representative, or Next of Kin (please print)

_____ _____ _____ _____

Signature of Claimant (if claimant is 18 or older) Date Signature of Authorized Representative of Next of Kin Date

_____

Relationship of Authorized Representative or Next of Kin to Claimant

LINCOLN MEMORIAL UNIVERSITY
INCIDENT REPORT

Full Name: _____
Street Address: _____
City/ST/Zip: _____
Birthdate: _____
Hire Date: _____ Position Title: _____
Male/Female **(circle one)**
Date/Time of Accident: _____ _____AM/PM
Date/Time Reported: _____ _____AM/PM
Time Employee Began Work: _____AM/PM
Names of Witnesses:
_____Interviewed: YES NO (attach documentation)
_____Interviewed: YES NO (attach documentation)
Treatment away from worksite?
Emergency Room: Yes / No
Physician or Other: _____
Facility: _____
Address: _____
Was injured person hospitalized overnight as inpatient? Yes / No
If injured person died, when did death occur? Date: _____

Name of building or area the injured person was in: _____

What was the injured person doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the injured person was using. Be specific. Examples: climbing a ladder while carrying roofing materials, spraying chlorine from hand sprayer, daily computer tasks. _____

What happened? Tell us how the injury occurred. Examples: When ladder slipped on wet floor, injured person fell 20 feet; injured person was sprayed with chlorine when gasket broke during replacement; injured person developed soreness in wrist over time. _____

What was the injury or illness? Tell us the part of the body that was affected and how it was affected. Example: Lower back pain; complains of wrist pain. _____

What object or substance directly harmed the injured person? Examples: Concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank. _____

Cause: Reason(s) for accident. Contributing factors, unsafe acts, unsafe conditions? _____

Prevention: Describe how to prevent a similar accident. _____

What action do you need to take? _____

Signature of Supervisor: _____ **Date**: _____
(If applicable)
Signature of Injured Person: _____ **Date:** _____
(If injured person refuses to sign, please note here)

Has corrective action been taken to prevent a similar accident? YES NO

By whom and what action was taken? _____