School of Medical Sciences 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 *Injury Report 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 items by e-mail to the respective Clinical Team, as well as norma.wells@lmunet.edu.

LMU- School of Medical Sciences
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, "Bloodborne Infectious Diseases: Emergency Needlestick Information". Students should familiarize themselves with this information. https://www.cdc.gov/niosh/topics/bbp/emergnedl.html

If a student experiences a needle stick, sharps injuries or is otherwise exposed to the blood of a patient while performing student activity, 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 Program Faculty during the Didactic Phase of training, or the clinical preceptor and the Clinical Team during the Clinical Phase of training. 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 post exposure prophylactic treatment (PEP) 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. During the Didactic Phase, students will be referred to the emergency department of the closest hospital. If in an office, contact the office manager 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 for the site. 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 Injury Report (attached). **The student should report the incident to the Clinical Team and complete the LMU Injury 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 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

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

STUDENT ACCIDENT CLAIM FORM

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

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501
Phone (269) 381-6630
Fax (269) 381-3055

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO →

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

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

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.

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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)

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

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

_____ _____
Signature of Authorized Representative of Next of Kin Date

_____
Relationship of Authorized Representative or Next of Kin to Claimant

Lincoln Memorial University

INJURY REPORT FORM

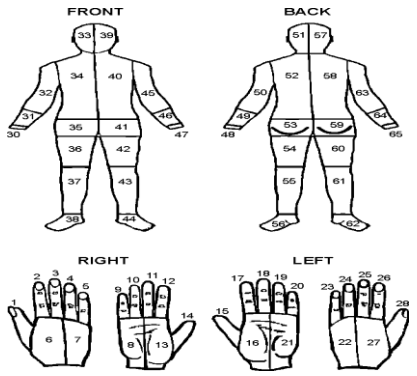
Instruction:

- Report the accident/injury/exposure (incident) to your Supervisor/Instructor immediately.
- Fill out this form, completing **all** sections, sign, and date it.
- Ensure your supervisor signs and dates the bottom of the form.
- Submit the form to riskmanagement@LMUnet.edu and norma.wells@lmunet.edu immediately following the incident (within 24 hours)
- If injured person is unable to complete this document, their direct supervisor is responsible for completing the steps above.

<table>
<tr><th colspan="6">INFORMATION</th></tr>
<tr><td colspan="3">Name:</td><td colspan="3">Division:</td></tr>
<tr><td colspan="2">LMU ID #:</td><td>Date of Birth:</td><td>Age:</td><td colspan="2">Male ☐ Female ☐</td></tr>
<tr><td colspan="6">Address: (Address/ P.O Box, City, ST ZIP Code)</td></tr>
<tr><td colspan="2">Email address:</td><td colspan="2">Home Phone:</td><td colspan="2">Cell Phone:</td></tr>
<tr><td colspan="2">Witness:</td><td colspan="2">Phone #:</td><td colspan="2">Email:</td></tr>
<tr><td rowspan="5">Incident</td><td>Campus/Facility of Incident</td><td>Date of Incident: (mm/dd/yy)</td><td>Time of Incident: (AM/PM)</td><td colspan="2"></td></tr>
<tr><td colspan="2">Exact Location of Incident: (parking lot, elevator, stairwell, etc.)</td><td>Type of Incident: Indicate all applicable</td><td colspan="2">☐ Unsafe Conditions</td></tr>
<tr><td>Bldg. Name</td><td></td><td>☐ Injury</td><td colspan="2">☐ Incident/Near Miss</td></tr>
<tr><td>Room #</td><td></td><td>☐ Property</td><td colspan="2">☐ Security</td></tr>
<tr><td colspan="2"></td><td>☐ Exposure ☐Other:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Police Department Contacted: ☐ No ☐ Yes (If yes, indicate department)</td><td colspan="3">Police Incident Report #:</td></tr>
<tr><td colspan="6">Description of Incident: (use second page if needed)</td></tr>
<tr><td colspan="6"></td></tr>
</table>

If injury occurred describe the nature of Injury or Illness (fracture, cut, allergic reaction, etc.):

If an injury occurred, please indicate injured area of the body by number on diagram: _____



Medical Treatment Required: ☐ No ☐ Yes (if yes please indicate) ☐First Aid Only ☐ Doctor/Clinic ☐ Emergency Room ☐ Other:	Date of First Treatment: Place of Treatment:

Type of Medical Treatment			
☐ Hospitalization	☐ Fracture	☐ Suture	☐ Referred for further treatment
☐ Prescription Medicine	☐ Foreign Object Removed	☐ Splint or Cast	
☐ Other: (Describe treatment, use second page if needed)			

Prevention: Describe how to prevent a similar accident.	
Supervisor	

Student or Person Completing Report (Print Name)	Supervisor (Print Name)
Signature Date	Signature Date

Office Use ONLY	Report received from: Date Report Received: Identifier #: