Section Six: Student Health Services Information

Contacts:

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TIPS FOR INSURANCE COVERAGE FOR SUMMER CAMPERS

1. See page 17, “What is Covered by Insurance,” to determine if the program is covered 24 hours a day or only for “sponsored” camp activities. If the program is not covered 24 hours a day, any illness or injury that occurs during non-sponsored activity would not be covered.


3. On your CU Health Examination Form, please make sure the parental consent for treatment is signed by parent/guardian for any participant under the age of 18.

4. Student Health Services typically serves youth ages 12 and above.

NON-COVERED ILLNESSES/INJURIES

1. If the program is not covered 24 hours a day, only injuries/illnesses that occur during “sponsored” activities are covered.

2. Pre-existing conditions are not covered, for example, if participant comes to campus with an injury or illness and needs follow up treatment, Redfern cannot do that here unless the participant has the means to pay for service when rendered. Other examples include a participant that needs a refill on asthma inhaler, etc., this is considered a pre-existing condition and would not be covered.

3. Gynecological problems, menstrual cramps, pregnancy tests, sexually transmitted infection testing and ingrown toenails are not covered.

If a program participant has a non-covered illness or injury and wishes for private insurance to be filed, they can be taken to ClemsonConnect Health Center/Urgent Care at 885 Tiger Blvd across from Subway. Tel. (864) 654-6800

STUDENT HEALTH SERVICES INFORMATION FORM

If a participant uses Student Health Services, the Clemson University Youth Camp/Program Health Examination Form or the Redfern Health Center/Clemson
University Special Groups, Summer Camps, and Visitors on Campus form must be presented at the time of service.
American Income Life
SPECIAL RISK Claim Report Form

Policy # 5534

Name of Policy Holder/Group: Clemson University

Name of Patient:

Patient Date of Birth: ____________________________ Age: ______ Sex: M F

Patient Home Address:

City: ____________________________ State: ______ Zip: ______

Patient is:
- [ ] Camper/Member
- [ ] Counselor/Instruction
- [ ] Salaried Staff
  - Eligible Work Comp.
- [ ] Summer Staff
- [ ] Volunteer Leader

Injury - Illness Report

Date of Injury/Illness: ____________________________
Time: ____________________________

Nature of Injury or Illness:

Was this condition already present before this person became insured? [ ] Yes  [ ] No

Describe How and Where Injury Occurred (explain fully):

If yes, please explain:

If there was no medical treatment during insured period, was injury or illness reported to staff member?  [ ] Yes  [ ] No

Office Use:

Verification Signature

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the:  [ ] Camp Director  [ ] Extension Personnel  [ ] Group Leader  [ ] Other (define) ______________________

Name of Camp: ____________________________

Contact (Print Name): ____________________________ Title: ____________________________

Signed: ____________________________

Day Time Phone: ____________________________ Email: ____________________________

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.

Send completed claim forms to:
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Email: claims@americanincomelife.com
Fax: 317-849-2793

Contact the Claims Department with questions.
Phone: (800) 849-4820 Email: claims@americanincomelife.com

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Claim Report Form

Name of Patient: __________________________  Patient Date of Birth: ____________

Patient Home Address __________________________

City __________________________  State ______  Zip ________

Assignment Form – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

(Payee Name) ___________________________________________ is to be reimbursed.

Address __________________________________ City __________________________  State ______  Zip ________

Phone #: __________________________  Email: __________________________

Date __________________________  Signed __________________________

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

______________________________  __________________________
Signature of Patient/Guardian/ or Personal Representative  Date

Send completed claim forms to:
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Email: claims@americanincomelife.com
Fax: 317-849-2793

Contact the Claims Department with questions.
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How to File a Claim

1. Written notice of claim, or Claim Report Form, must be provided to the company within twenty days from the date of incident covered by this policy, but no later than ninety days from the date of incident.

   - Complete the entire claim report (Parts 1-6); the claim report must be signed by a camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT.

   - Valid claim reports must contain the following information:
     a. Policy number and serial number
     b. Full legal name of the injured/ill person (patient)
     c. Patient’s date of birth & age
     d. Current mailing address
     e. Date of the incident (injury or illness)
     f. How injury was sustained or the nature of the illness
     g. Verification signature by Camp Director, Extension Personnel, Group Leader, or Chaperone
     h. Signature for Release of Medical Information Authorization

2. Eligible medical statements must be provided within one year from the date of treatment.
   For claim review provide:

   a. Itemized statements for services rendered by physician or hospital, including diagnosis and procedure codes.
   b. Prescription receipts complete with patient’s name, Rx number, name of prescription, and price.
   c. Proof of payment along with an itemized bill if payment has been made.
      *Proof of payment would be a paid receipt from provider, credit card receipt, or cancelled check.*
   d. Explanation of Benefits for claims paid by personal insurance.

NOTE:
Payment is made directly to the medical provider unless otherwise indicated on the Assignment Form (Part 5).

Mail, Fax, or Email the completed Claim Report Form directly to the company.
DO NOT rely on medical providers to forward.

American Income Life Insurance Company
Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 800-849-4820
Fax: 317-849-2793
Claim Department Email: claims@americanincomelife.com
Web: www.americanincomelife.com