SCHOOL ACTIVITIES

Florida State College at Jacksonville
Notification of Injury

Mail to: Florida State College at Jacksonville, Risk Management Department, 501 West State Street, Jacksonville, FL 32202

A. Excess Coverage—Eligible covered expenses will be reimbursed only if they are in excess of valid and collectible insurance. You must submit the claim to your primary insurance before we can compute payment.
B. The claim must be submitted within 90 days from the date of service. Physician's service must begin within 60 days of accident.
C. All bills submmitted must be ITEMIZED for services and show dates for each service or treatment.
D. Forward additional bills to the address above. No additional claim forms are needed, please note the school and student name on any additional bills.

Part A — TO BE COMPLETED BY STUDENT

NAME OF STUDENT (Last Name) (First Name) (Middle Initial)	PATIENT'S DATE OF BIRTH	SEX ☐ M ☐ F
PATIENT'S STUDENT ID NUMBER	DATE & TIME OF ACCIDENT	
NATURE OF INJURY		

FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT _____

_____

B PLACE OF ACCIDENT (BE SPECIFIC)
_____

C. DESCRIBE HOW ACCIDENT HAPPENED _____

D. IF CLAIM IS FOR A SPORTS INJURY, WAS IT AN INTERSCHOLASTIC SPORT? ☐ YES ☐ NO

Is student covered under any health/accident insurance or prepayment plan? ☐YES ☐ NO
If yes, please list names, policy number, and address and identifying information.
Please submit a copy of an Explanation of Benefits from your other insurance carrier or prepayment plan.

_____
_____
_____
_____
_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Florida State College at Jacksonville, Risk Management Department or their employees and authorized agents for the purpose of validating and determining payment. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

NAME OF STUDENT	SIGNATURE OF STUDENT (PARENT OR GUARDIAN IN THE EVENT OF MINORITY OR INCAPACITY)	DATE SIGNED

PAYMENT AUTHORIZATION

I authorize payment directly to those physicians or providers described below, and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me.

SIGNATURE OF INJURED (PARENT OR GUARDIAN IN THE EVENT OF MINORITY OR INCAPACITY)	DATE SIGNED

Part B	TO BE COMPLETED BY COLLEGE OFFICIAL			
				NAME OF COLLEGE OR UNIVERSITY **FLORIDA STATE COLLEGE**
ADDRESS OF SCHOOL (Street) 501 West State State Street	(City) Jacksonville,	(State) FL	(Zip Code) 32202	TELEPHONE NUMBER (904) 632-3127

DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.

REMARKS:

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

AUTHORIZED SIGNATURE	TITLE	DATE