

“I am Enrolled...Now What?”

ID Cards & My Accounts:

Students will receive an email prompting them to create a My Account once you send the enrollments over to be processed (24-48 hours normally, but in Aug/Sept can take 5-7 days). If for some reason a student comes to you and says they did not receive the email they can also just go to www.uhcsr.com, enter your school name, then click on “ID Card” which will redirect them to the page where they can create their “My Account”.

Students can also access their account through **phone app “UHC Student Resources”**.

11.0 is the minimum version required for the app to function correctly right now for iOS iPhone users

My Accounts:

Students must manage their online account. The My Account is where ALL communication is sent including claim status, EOB's, pending information, payments, etc. This not sent in the mail. **2-step Verification Process:** There is a 2-step verification process every time you access the My Account (even when creating it). It will verify by sending a code to either a cell phone or the student's email address.

PRA Form: Should someone need to assist with student claims and need to reach out to the carrier then they must be listed on the PRA form (Personal Representative Appointment). This can also be completed by the student within their My Account or you can print this out and have the students sign in person.

Student Status Letter: Once a \$1000 threshold of any sickness or accident claims has been paid by UHCSR a “Student Status Letter” will generate within the students “My Account”. This must be verified and signed by the school registrar or a designated person from the school (submit name ahead of time). Claims will NOT be paid until this is completed.

Sample Check List:

Once Enrolled:

- ✓ Create My Account (Student or Admin and Student)
- ✓ Save User Name and Password
- ✓ Once logged into the My Account:
 - Add designated cell phone number to profile
 - Assign PRA person (name, phone number, email and address of school staff member who will be helping).

Claim Utilization

- ✓ “Student Status Letter” print this document within the My Account and have completed once a \$1000 threshold of claims have been paid in sickness and/or accidents
- ✓ Always Check My Accounts for notifications about Claims and Pending Information.

UHCSR 800 number to call if questions on claims 1-800-767-0700 or customerservice@uhcsr.com

Sample Check List:

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Claim Utilization

- ✓ “Student Status Letter” print this document within the My Account and have completed once a \$1000 threshold of claims have been paid in sickness and/or accidents
- ✓ “IC Sports Packet” Notification of Claim – Student and Admin submits completed form to UHCSR (email, fax and address are on the form)
- ✓ Always Check My Accounts for notifications about Claims and Pending Information.

Claim Resources:

UHCSR 800 number to call if questions on claims [1-800-767-0700](tel:1-800-767-0700) or customerservice@uhcsr.com

UHCSR Claims manager –Helen Sanchez hsanchez@uhcsr.com Phone 888-767-0700 x6617 *for school only*

United Health Care student resources website www.uhcsr.com

Address for sending paperwork / claims if needed –

Submit claims within 90 days after date of service.
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, TX 75380-9025

Preventive Care Services – Must be coded with preventive service and diagnosis codes to be covered as preventive care.

Documents:

- PRA Form – Personal Representative Appointment to be completed by registrar and/or designated staff member in athletics.
- ICS Claims Packet – Needs Completed by School Representative and Student
- UHCSR Contact Sheet – For Admin use only. No students.
- My Account – Student Flyer
- Phone App – Student Flyer
- Partner Center Access Form
- Preventive Care Services – Code PDF



Sports Injury Claim Submission Guide for Student

Below are procedures for submitting sports injury claims to UnitedHealthcare **StudentResources** (UHCSR).

What to do after an injury occurs

- As soon as possible after an injury occurs, contact the designated person at your school (Athletic Director, Coach, Trainer or Properly Delegated Authority) to obtain the Notification of Claim Form (NCF) and the ID card image.
- Have the authorized person mentioned above complete **Part I** of NCF and sign it. You will need to complete **Part II** on the form. Your parent or guardian must sign the form if you are under age 18.
- Be sure to put the policy number (e.g. 2017-234567-8) on the NCF as shown on the ID card image. The fields for *Claim Number* and *7 digit # on ID card* can be left blank if they are not available. Give a copy of the completed NCF and the ID card image to the provider of services for your injury. Have them include the NCF when they submit the claim to UHCSR so that your claim will be paid under the correct benefits.

If you have other insurance coverage

- If your plan with UHCSR pays benefits in excess of other insurance, your claim will need to be submitted to the primary insurance carrier first.
- After your claim is processed by the primary insurance carrier, submit the following to UHCSR:
 - Detailed receipt or bill (must include diagnosis, procedure code, service date and cost)
 - Explanation of Benefits (EOB) from the primary carrier
 - Notification of Claim Form (NCF)

How to submit Claim Documents

- Email: SI.DRG@uhcsr.com
Attach scanned copies and include in subject line: ADA/IC Sport Claim
OR
- Mail: UnitedHealthcare StudentResources
Attn: ADA/IC Sport Claim Forms
PO Box 809025
Dallas, TX, 75380-9025

If you need someone to help with your Claim

- Complete a Personal Representative Appointment Form (PRA)
- Submit the PRA online through **My Account** at www.uhcsr.com. If you don't already have access to **My Account**, you will need to create one by visiting: www.uhcsr.com/CreateAccount, provided you also have medical coverage with UHCSR.
- The PRA form may be available from your Athletic Department, or you can request one by contacting Customer Service (see below).

Questions? Contact Customer Service

- Phone: 1-800-767-0700 (Hours 7:00am-7:00pm Central Standard time)
Select "0" to speak with a representative*
- Email: claims@uhcsr.com for claim questions*
customerservice@uhcsr.com for general Customer Service inquiries*

*Identify that you are an athlete and provide your school name and policy number (e.g. 2017-234567-8) on the ID card image



**NOTIFICATION OF CLAIM FORM –
UNITEDHEALTHCARE STUDENTRESOURCES
ADA (Injury Only)/IC Sport Claims**

| |
|-----------------------------------|
| Policy Year: |
| Policy Number: |
| Claim Number: |
| Student ID (7 digit # on ID card) |

If you are completing this form online, please print the form, sign, and follow one of the submission methods below. Press the tab button to move from one box to the next. The text font will automatically decrease in size to fit the allotted space if the data entered is larger than the box provided. If additional space is needed, you can use a separate sheet of paper and attach it to this form.

Claim Instructions: A completed Notification of Claim Form is required per accident and/or occurrence. The School or Provider must have this form completed as soon as possible after the injury occurs and submit using one of the following methods:

MAIL: UnitedHealthcare StudentResources, P.O. Box 809025, Dallas, TX 75380-9025

EMAIL: A scanned copy of the completed form to SI.DRG@uhcsr.com

Questions? Call Customer Service Toll Free Number: 800-767-0700

PART I – TO BE COMPLETED BY COACH, ATHLETIC TRAINER OR PROPERLY DELEGATED AUTHORITY

| | | | | | |
|---|--------------------------|--|---|--|------------------|
| 1. College/University | | | 2. Campus Location | | |
| 3. Name of Individual | | Last | First | Middle | 4. Date of Birth |
| 5. Date of Injury | 6. Place Injury Occurred | | 7. Sports activity (if applicable, check one and specify type of sport in space provided): a) Intercollegiate Sport <input type="checkbox"/> Interscholastic Sport <input type="checkbox"/> Club Sport <input type="checkbox"/> Intramural Sport <input type="checkbox"/> b) Type of Sport (football, basketball, track, etc.): | | |
| 8. Nature of Injury | | | | | |
| 9. Describe how accident occurred (give all possible details). Must be a bodily injury due to an accident. | | | | | |
| 10. Did accident occur: | | | | | |
| a) While claimant was supervised? Yes <input type="checkbox"/> No <input type="checkbox"/> | | b) During sponsored activity? Yes <input type="checkbox"/> No <input type="checkbox"/> | | c) During programmed hours? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d) On activity premises? Yes <input type="checkbox"/> No <input type="checkbox"/> | | e) While traveling to or from a regularly scheduled activity in a supervised group? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 11. If injury occurred in a previous policy year, is the student still an athlete in the current policy year? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> | | | 12. Is the above claimant a regular member of the policyholder and injured while a regular member of such team and in the manner described above? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 13. Signature (Coach, Athletic Trainer or Delegated Authority) | | 14. Title | | 15. Date | |

PART II – TO BE COMPLETED BY CLAIMANT OR BY PARENT, GUARDIAN OF CLAIMANT

| | | | |
|--|--|----------------------|--|
| 16. Name of Parent or Guardian | | 17. Telephone number | |
| 18. Mailing Address of Insured (Parent or Guardian if Insured is under age 18) | | 19. Email address | |

OTHER INSURANCE INFORMATION

| | | |
|---|------------------------------|--------------------------------------|
| 20. Is patient covered by another insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked "Yes", please complete the section below. | | |
| 21. Name of person carrying other insurance: | 22. Subscriber #: | 23. Name of other insurance carrier: |
| 24. Other Insurance Policy #: | 25. Other Insurance Phone #: | 26. Policyholder's Date of Birth |

IMPORTANT: PLEASE REFER TO FRAUD WARNING STATEMENTS ON THE SECOND PAGE OF THIS FORM.

Authorization: I hereby certify that the injury occurred as stated and that all treatments listed were due entirely to the injury, that the injury was not a result of a congenital, pre-disposing or pre-existing condition. I hereby authorize any physician or hospital that has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian if Insured is under age 18)

Date

My Account: Sample My Account Creation: Go to www.uhcsr.com, enter your school name, then click on "ID Card" which will redirect them to the page where they can create their "My Account".

Login to My Account to access and manage your policy.

Login to My Account

Enter your username and password to continue...

Username*

Password*



Did you forget your [Username](#) or [Password](#)?

**CREATE
ACCOUNT**

**SACM MEMBER
CREATE ACCOUNT**

LOGIN

My Claims/Balances: Claim Information

UnitedHealthcare | StudentResources

HOME MY COVERAGE BENEFITS CARE OPTIONS MESSAGES ACTION CENTER NEED ASSISTANCE?

My Account

My Claims/Balances

- Pending Claims**
Summary of claims pending and in progress
- Completed Claims**
Summary of finalized claims
- Member Balances**
Deductible and Out-of-Pocket Balances

My Benefits

- Medical**
- Additional Benefits**

Care Options

- Not Sure Where To Go?**
Know your care options and cost
- Find Provider & Cost Estimator**
Locate a Healthcare Provider
- Student Health Center**
Your school's Student Health Center
- Telehealth Medical**
24/7 doctor access
- Pharmacy Locator**
Find a pharmacy nearby

Explore More

ID Card

Print, View, or Request ID card

Enroll Dependent

Enroll dependents on your plan

Coverage Information

View coverage details

Need Assistance?

How may we help you?

Claim Summary

My Account

Claim Summary | Claim Letters | Manage Accident Details

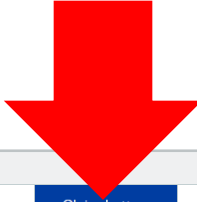
CLAIM SUMMARY

Completed Claims (134) Pending Claims (13)

Filter by Member Name: All Members | Filter by Provider: All Providers | Sort by Date

| Patient | Provider | Date Of Service | Claim | Paid | View Details |
|------------|--------------------------------|-----------------|----------|----------|--------------|
| [Redacted] | Allergy Immunology Specialists | 06/03/2019 | \$26.13 | \$7.42 | View Details |
| [Redacted] | Allergy Immunology Specialists | 05/16/2019 | \$960.00 | \$276.48 | View Details |

Claim Letters



My Claims

Claim Summary **Claim Letters** Manage Accident Details

CLAIM LETTERS ?

✔ Action Required - Open (1) ✉ Closed/Past Due (6) ⓘ Informational Only (35)

■ No Response ■ Incomplete ■ Complete

| Sent on | Patient | Description | |
|------------|------------|---|-------------------------------|
| 05/28/2019 | [Redacted] | Request For Other Insurance Information | Submit Online View Letter |
| 01/11/2019 | [Redacted] | Request For Accident Details | View Letter |
| 12/20/2018 | [Redacted] | Request For Accident Details | Submit Online View Letter |
| 11/19/2018 | [Redacted] | Request For Accident Details | View Letter |
| 10/26/2018 | [Redacted] | Request For Accident Details | Submit Online View Letter |
| 05/16/2018 | [Redacted] | Request For Accident Details | View Letter |

Manage Accident Details



My Claims

Claim Summary Claim Letters **Manage Accident Details**

MANAGE ACCIDENT DETAILS ?

Submit New Accident Details

| Patient | Accident Date | Accident Type | Submitted | |
|------------|---------------|----------------|------------|--|
| [Redacted] | 01/02/2018 | Sports Related | 05/21/2018 | Attach Document (1/4) View Details |

Personal Representative Appointment

I, _____,
(Please Print)

do hereby appoint _____
(Please Print)

as my personal representative to act on my behalf in the matters of health insurance with UnitedHealthcare **StudentResources**.

I understand this is a voluntary designation and that this designation gives the personal representative the same rights to my health insurance information as myself. This appointment will expire at the end of the current academic/policy year.

Please complete the following information and fax it to 469-229-5510.

To expedite the process, please go to our website at www.uhcsr.com and access your existing account or create My Account then submit this form online.

| |
|---|
| INSURED INFORMATION |
| Insured's Name |
| Insured's Policy # (as shown on ID Card) |
| SRID # ID Number (as shown on ID Card) |
| Insured's Address |
| Date |

| |
|--|
| PERSONAL REPRESENTATIVE INFORMATION (Necessary for Identity Verification) |
| Personal Representative's Name |
| Personal Representative's Address |
| Insured's Signature |