



Education and Leadership for a Lifetime

2100 Freeway Boulevard, Brooklyn Center, Minnesota 55430-1735 | (763) 560-2262, FAX (763) 569-0499 | www.mshsl.org

Date: September 2017

To: Athletic/Activities Directors of MSHSL Member Schools

From: Rich Matter
Assistant Director
MSHSL

Re: HeadStrong Concussion Insurance Program provided by the MSHSL

The MSHSL is pleased to provide member schools the HeadStrong Concussion Insurance Program which is specifically developed to insure student athletes/participants from the high cost of concussion treatment and neurological follow up.

The coverage period is August 1, 2017 - August 1, 2018. All students are eligible for coverage in grades 7-12, participating in activities, practice or play of sports, at the Varsity, Junior Varsity, B-Squad and Sophomore level. Program highlights include:

- \$0 deductible and no co-pays
- \$25,000 per injury medical maximum
- Coverage is secondary/excess to any other valid and collectible insurance
- Coverage will become the primary payor, if no other insurance is available
- 1-year benefit period from the injury date
- Accidental Death and Dismemberment \$5,000
- No restrictions on specific doctors
- No referral needed for treatment

Attached please find:

- Program Guide - (How to Submit a Claim)
- HeadStrong Concussion - Claim Form
- HeadStrong Concussion – Other Insurance Form

For more details regarding this new insurance program contact Rich Matter at rmatter@mshsl.org



Concussion Insurance Program Guide

Headstrong Concussion Insurance Policy Information Minnesota State High School League

Broker: Dissinger Reed

Third Party Administrator (TPA): K&K Insurance

Insurance Carrier: Nationwide Life Insurance Company – AM Best-Rated A+XV

The HeadStrong Concussion Insurance Program was specifically developed to insure student athletes from the high cost of concussion treatment and neurological follow up.

The student athlete has 'first dollar' coverage (zero deductible) for concussion assessment and treatment.

Coverage is secondary/excess to any other valid and collectable insurance but will become the primary payor, if no other insurance is available.

Program Highlights Include:

- \$0 deductible and no Co-pays
- Tele-med Services, when needed
- No restrictions on specific doctors
- No referrals needed for treatment
- No internal limits
- No specific procedure maximums
- Neurological follow up care When medically necessary and billed at U&C.

- **Policy #:** JXS0000028405500
- **Coverage Period:** August 1, 2017 – August 1, 2018
- **Deductible:** \$0 per claim
- **Eligible Person:** All students, grades 7-12, participating in a Covered Activity at the Varsity, Junior Varsity, B-Squad and Sophomore level.
- **Covered Activities:** Participating in activities, practice or play of sports governed and/or sponsored by the MSHSL
- \$25,000 per injury medical maximum
- 1-year benefit period (Benefits will be payable for 1 year from the injury date)
- Usual and Customary 100%
- Accidental Death & Dismemberment \$5,000
- Accidental Death and Dismemberment Aggregate \$250,000

Contact for Claims:



kk.newpaclaims@kandkinsurance.com



Fax: (260) 459-5915
Phone: (800) 237-2917



K&K Insurance/Specialty Benefits
1712 Magnavox Way
Ft. Wayne, IN 46804

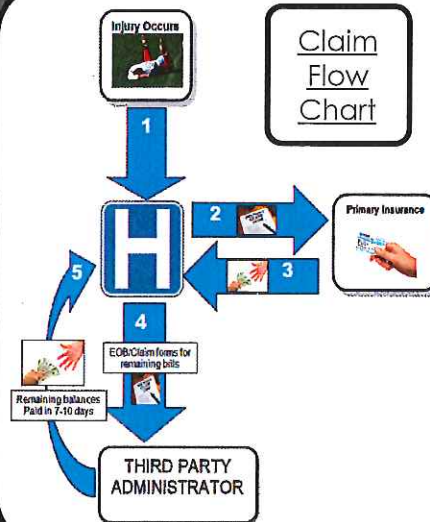
Please submit the completed and signed claim form along with itemized bills and EOB's from the primary insurance carrier. The more information you can provide upfront, the better. Claims payments are expedited with CLEAN submissions allowing us to pay you providers quickly.

Third Party Administrator



www.kandkinsurance.com

Claim
Flow
Chart



HOW TO SUBMIT A CLAIM UNDER THE CONCUSSION PROGRAM

- 1) Submit the incident report within 365 days of the injury.
- 2) Make certain that the incident report is completed in its entirety, including the policy number (JXS0000028405500), with accurate and detailed injury information and how the accident happened.
- 3) The incident report **MUST BE SIGNED** by a representative of the school. **INCIDENT REPORTS WHICH ARE NOT SIGNED, WILL DELAY THE CLAIM.**
- 4) Physician billings on CMS1500 forms and hospital/facility billings on UB04 forms would be preferred as these forms contain all the necessary coding required to process a claim. See bullets #5 & 6 for additional instruction regarding bills.
- 5) If the injured participant has primary insurance, each bill should be submitted with the primary insurance Explanation of Benefits or denial.
- 6) If the injured participant has primary insurance, all providers should be informed of the primary insurance information so they are billed first, and the K&K information for the concussion program insurance billed second.
- 7) When the injured participant does not have primary insurance, we have agreements through PPO networks that allow many bills to be reduced with contractual discounts. We encourage injured participants **NOT** to pay claims in advance of submitting them to us. so these discounts can be used.

PRIMARY CONTACT

James Maxwell



1660 School St.
Ste 101A
Moraga, CA 94556
Phone:(415) 517-4545

jmaxwell@dissingerreed.com





1712 Magnavox Way P.O. Box 2338
 Fort Wayne, Indiana 46801
 PH (800) 237-2917
 Fax (312) 381-9077
 http://www.kandkinsurance.com

K&K INCIDENT REPORT

Minnesota State High School League
 Concussion Coverage

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ CONDUCTED BY: _____ LOCATION: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female PHONE: () _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> OTHER: _____
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____
OTHER SCHOOL INSURANCE	DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: _____ _____ _____
INSURED	NAME OF INSURED: Minnesota State High School League POLICY#: JXS0000028405500 CLUB NAME: _____ PHONE: () _____ CITY: _____ STATE: _____
INSURED REPRESENTATIVE	<input type="checkbox"/> MSHSL Member School Administrator <input type="checkbox"/> OTHER: _____ NAME: _____ PHONE: () _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____

COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:
K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338
 THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE
 BEFORE RETURNING OR PROCESSING MAY BE DELAYED



1712 Magnavox Way P.O. Box 2338
 Fort Wayne, Indiana 46801
 (800) 237-2917 Fax (312) 381-9077
 email: KK.PAclaims@kandkinsurance.com
 http://www.kandkinsurance.com

PARTICIPANT ACCIDENT OTHER INSURANCE FORM

Insured Name: _____
 Policy Number: _____

**IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED,
 OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.**

TO BE COMPLETED BY INJURED PERSON OR PARENT PART II

MEDICAL BENEFITS UNDER THIS POLICY MAY PROVIDE PRIMARY, EXCESS OR A COMBINATION OF BOTH COVERAGES. UPON RECEIPT OF THIS CLAIM FORM, AN ACKNOWLEDGEMENT LETTER WILL BE SENT TO YOU ADVISING WHAT SPECIFIC BENEFITS YOU ARE ENTITLED TO.

IF THE MEDICAL BENEFIT IS EXCESS, YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

INJURED PERSON: _____
 FATHER'S NAME (if injured is a minor) _____
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (____) _____
 GROUP INSURANCE COMPANY: _____
 POLICY NUMBER: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 DATE OF BIRTH: _____
 SIGNATURE: _____

SPOUSE'S NAME (if applicable) _____
 MOTHER'S NAME (if injured is a minor) _____
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (____) _____
 GROUP INSURANCE COMPANY: _____
 POLICY NUMBER: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 DATE OF BIRTH: _____
 SIGNATURE: _____

QUESTIONS REGARDING INCOME ARE ONLY APPLICABLE IF POLICY AFFORDS WEEKLY INDEMNITY BENEFITS.

REGULAR WEEKLY INCOME: _____
 ON WHAT DATE DID YOU, OR DO YOU EXPECT TO,
 RESUME WORK? _____

INCOME LOST PER WEEK DUE TO INJURY: _____
 ON WHAT DATE DID YOU, OR DO YOU EXPECT TO,
 RESUME RACING AND/OR PARTICIPATE IN A RACING EVENT? _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.



OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT Yes No
 EMANCIPATED STUDENT: Yes No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: Yes No
 NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
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IS FATHER DECEASED? Yes No
 IS FATHER LEGALLY RESPONSIBLE? Yes No
 FATHER'S NAME (if injured is a minor) _____
 DATE OF BIRTH: _____
 EMPLOYED? Yes No SELF-EMPLOYED? Yes No
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? Yes No
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (_____) _____
 CONTACT PERSON: _____

Do you have group medical insurance coverage through your employment?
 Yes No
 If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 POLICY NUMBER: _____
 TYPE OF PLAN: HEALTH MAINTENANCE ORGANIZATION (HMO)
 PREFERRED PROVIDER ORGANIZATION (PPO)
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
 OTHER (describe) _____

IS MOTHER DECEASED? Yes No
 IS MOTHER LEGALLY RESPONSIBLE? Yes No
 MOTHER'S NAME (if injured is a minor) _____
 DATE OF BIRTH: _____
 EMPLOYED? Yes No SELF-EMPLOYED? Yes No
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? Yes No
 EMPLOYER NAME: _____
 EMPLOYER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: (_____) _____
 CONTACT PERSON: _____

Do you have group medical insurance coverage through your employment?
 Yes No
 If no, please be advised K&K may contact your employer to verify no primary insurance is in force.

INSURANCE COMPANY: _____
 INSURANCE COMPANY ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 POLICY NUMBER: _____
 TYPE OF PLAN: HEALTH MAINTENANCE ORGANIZATION (HMO)
 PREFERRED PROVIDER ORGANIZATION (PPO)
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE
 OTHER (describe) _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____
 DATE: _____

PARENT/GUARDIAN/MOTHER SIGNATURE: _____
 DATE: _____