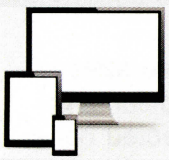
# Program Resources
# Accompanying Information

The HeadStrong Concussion Insurance Program was developed by Dissinger Reed to specifically 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 specific procedure maximums



**Contact for Claims:**
Cheryl Walsh - cheryl.walsh@mutualofomaha.com
(402)-351-5325
Fax: (402) 351-4732
Phone: (800) 524-2324
Mutual of Omaha:
3300 Mutual of Omaha Plaza
Omaha, NE 68175
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

## HeadStrong Concussion Insurance Policy Information

High School Association: Michigan High School Athletic Association

**Broker:** Dissinger Reed

Claims Payor: Mutual of Omaha

Insurance Carrier: Mutual of Omaha Company – AM Best Rated A+XV

Policy #: SR2014MI-P-054180-008
Coverage Period: August 1, 2021 – August 1, 202
Deductible: $0 per claim
Eligible Person: All athletes participating in a Covered Activity
Covered Activities: Participating in practice or pla of sports governed and/or sponsored by the MHSAA $25,000 per injury medical maximum
1-year benefit period (Benefits will be payable for year from the injury date)
Usual and Customary 100%
Accidental Death & Dismemberment $5,000 AD&
Aggregate $250,000

## HOW TO SUBMIT A CLAIM UNDER THE CONCUSSION PROGRAM

1) Submit the incident report within 30 days of the injury, or as quickly as possible.
2) Make certain that the incident report is completed in its entirety, including the policy number (SR2014MI-P-054180-008), 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 Mutual of Omaha information for the concussion program insurance billed second.
7) When an 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.

# HeadStrong
# Frequently Asked Questions

**Headstrong is an excess accident plan. What does that mean?**
*1. The Insurance will pay for covered charges after the primary insurance has been exhausted.*
*2. Also referred to as "secondary policy" - in that it will pay secondary to any primary insurance in*
*3. The insurance will also pay for any covered charges the primary insurance will not cover (includ deductibles, co-pays, any other out-of-pocket charges).*

**How do I submit a claim?**
*Full details are provided in the Program Guide. You will need to fill out and submit a claim form (in report), and Other Insurance Questionnaire to:*

*Mutual of Omaha*
*3300 Mutual of Omaha Plaza Omaha, NE 68175*
*Phone: 1-800-524-2324*
*Fax: 402-351-4732*
*Email: specialrisk.claims@mutualofomaha.com*

**I have primary insurance, what policy should I give to the provider?**
*It is best to give the provider BOTH: primary insurance information and the Mutual of Omaha information for the concussion program. The provider should then work directly with Mutual of O to bill primary insurance first, and the Headstrong Concussion Insurance second.*

**On the claim form: Insured Representative. Who is a Member School Administrator?**
*This can be a school administrator, athletic trainer, coach or another school representative. It is be have the school representative be a person who was present at the time of the accident.*

**Do I need a referral to see a concussion specialist?**
*There are no restrictions on specific doctors, and no referral is needed.*

**What is the policy deductible?**
*The policy deductible is $0. The insurance offers first dollar coverage for concussion assessment a treatment. The insurance will pay for out-of-pocket costs remaining from the student's primary insurance (co-pay, deductible, treatment not covered), or will become the primary payor, if no oth insurance is available.*

**I already paid the provider out-of-pocket, will the insurance reimburse me directly?**
*Yes. Please submit claim form, other insurance questionnaire, along with Bills and Explanation of Benefits to Mutual of Omaha. It is recommended to contact Mutual of Omaha prior to paying for services out of pocket.*

**What events are "covered events?"**
*Participating in practice or play of sports governed and/or sponsored by the State High School Association*

MHSAA®
michigan high school athletic association

Michigan High School Athletic Association
1661 Ramblewood Drive
East Lansing, MI 48823

Dear Provider:

The athlete that you are treating today is a member of the _____ team, which is a participating member of the Michigan High School Athletic Association (MHSAA).

The MHSAA has provided the athlete with an excess accident medical plan that pays for expenses related to the care of a concussion injury. This plan will pay for covered charges after the athlete's primary insurance has been exhausted. Mutual of Omaha is the claims administrator for the excess plan and the following information is being supplied to you in an effort to assist the claimant in obtaining maximum benefits in a timely manner.

Please submit all charges through any other primary insurance first, and then submit itemized bills (HCFA-1500 or UB-92) and the primary Explanation of Benefits to:

**Mutual of Omaha**
**3300 Mutual of Omaha Plaza**
**Omaha, NE 68175**
**Fax: 402-351-4732**

Should you have any questions or need any additional information, please feel free to call (800) 524-2324

Thank You

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# Claim Form - HeadStrong Concussion Insurance

Complete and return this form to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324

## Section I Organization/School and Claimant Information (required)

**TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL**

Policy Effective Date _____

Policy Expiration Date _____

Policy Number 054180-008

Claim being filed is a:

- ☐ Noncatastrophic claim
- ☐ Catastrophic claim

Policyholder Name Michigan High School Athletic Association

Policyholder Address _____
(Street) (City) (State) (ZIP Code)

Policyholder Phone Number _____

### Injured Party (Claimant) Information

Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Claimant is a: ☐ Player ☐ Coach ☐ Official ☐ Other _____

Verify that accident occurred during an activity sponsored or sanctioned by the policyholder, and whether claimant was a member at the time of the accident.

☐ Yes – Sponsored/Sanctioned activity

☐ Yes – Claimant was active member on date of accident

Under whose supervision? _____

Was he/she a witness? ☐ Yes ☐ No

Name of team/sport _____

Date of accident _____ Time of accident _____ ☐ a.m. ☐ p.m.

Location of accident _____

Type of activity _____

Accident occurred during: ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Interscholastic/Intercollegiate Sport
☐ Intramural Sport ☐ Other _____

I certify that the above information is true and correct.

Authorized Signature _____

Title _____ Date _____

## Section II Additional Claim Details (required)

**COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

Claimant Name _____

Describe accident _____

Body part injured _____

First treatment date _____

Dates claimed _____

Type of benefits claimed: ☐ Accident-Medical ☐ Dental ☐ Sickness-Medical ☐ Loss of Time

Name of family physician _____

Address _____

Phone Number _____

Has treatment been completed? ☐ Yes ☐ No

## Section III Statement of Other Insurance (required)

**COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

Father/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Mother/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Is Claimant covered under any other medical and/or dental insurance policy? ☐ Yes ☐ No

Is Claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐ Yes ☐ No

**Important Notice:** This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with an itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

**Details of Other Insurance Coverage (required)**
**COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

Insured Name _____ I.D. Number _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Insured Group Number/Name _____

Company Name _____

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

**Please include copy of insurance card (both sides)

**Note:** If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party:

Responsible Party Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

## Section IV Statement of Certification (required)

**COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. (PURSUANT TO 11 NYC RR86)

Signature of Parent/
Guardian/Claimant (required) _____ Date _____

## Section V Authorization to Release Information (required)

**COMPLETED BY CLAIMANT, PARENT OR GUARDIAN**

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent/
Guardian/Claimant (required) _____ Date _____