Program Resources

Claim Submission

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, 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.

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.

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 054180-010

Claim being filed is a:

☐ Noncatastrophic claim

☐ Catastrophic claim

Policyholder Name Missouri State High School Activities 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 _____

Has there been a previous concussion ☐ Yes ☐ No

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 _____

Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **Arkansas, Louisiana and Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** 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.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Missouri State High School Activities Association
1 North Keene St.
PO Box 1328
Columbia, MO 65201

Dear Provider:

The athlete that you are treating today is a member of the _____ team, which is a participating member of the MSHSAA.

The State High School Association 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:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324
Email: specialrisk.claims@mutualofomaha.com

Carol Grabenschroer – Claims Manager
Phone: 402-351-3807
Email: carol.grabenschroer@mutualofomaha.com

Candice Little – Claims Manager
Phone: 402-351-3265
Email: candice.little@mutualofomaha.com

Should you have any questions or need any additional information, please feel free to call Justin Vandewynkle at 913-488-9449.

Thank You,

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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 place.
3. The insurance will also pay for any covered charges the primary insurance will not cover (including deductibles, co-pays, and any other out-of-pocket charges).

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 Omaha to bill primary insurance first, and the Headstrong Concussion Insurance second.

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 and 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 other insurance is available.

I already paid the provider out-of-pocket, will the insurance reimburse me directly?

Yes. Please submit the 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.

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 (incident report), and Other Insurance Questionnaire to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324
Email: specialrisk.claims@mutualofomaha.com

Carol Grabenschroer – Claims Manager
Phone: 402-351-3807
Email: carol.grabenschroer@mutualofomaha.com

Justin Vandewynkle – HeadStrong Program Manager
Phone: 913-488-9449
Email: justin.vandewynkle@hubinternational.com

Candice Little – Claims Manager
Phone: 402-351-3265
Email: candice.little@ mutualofomaha.com

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 best to have the school representative be a person who was present at the time of the accident.

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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

HeadStrong Concussion Insurance Policy Information

State High School Association: Missouri State High School Activities Association
Broker: Dissinger Reed
Claims Payor: Mutual of Omaha
Insurance Carrier: Mutual of Omaha Company – AM Best Rated A+XV

Policy#: SR2014MO-P-054180-010

Coverage Period: September 1, 2024 - September 1, 2025
Deductible: $0 per claim
Eligible Person: All athletes participating in a Covered Activity
Covered Activities: Participating in practice or play of sports governed and/or sponsored by the MSHSAA.
Medical Maximum: $25,000 per injury
Benefit Period: 1-year (Benefits will be payable for 1 year from the injury date)
Usual and Customary: 100%
Accidental Death & Dismemberment: $5,000
AD&D Aggregate: $250,000

Contact for Customer Service/Claims:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324
Email: specialrisk.claims@mutualofomaha.com

Carol Grabenschroer – Claims Manager
Phone: 402-351-3807
Email: carol.grabenschroer@mutualofomaha.com

Candice Little – Claims Manager
Phone: 402-351-3265
Email: candice.little@mututalofomaha.com

Justin Vandewynkle – HeadStrong Program Manager
Phone: 913-488-9449
Email: justin.vandewynkle@hubinternational.com

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.