K-12 Fast Track

To submit a claim on behalf of a student, click here. If you have not yet submitted any claims, this empty claim form will appear.

Use the dropdowns provided to auto-populate the fields. Complete the entire form. The system will alert you if a required field is left blank.

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail to HSR
Email: K12Claims@HSRI.com

HSR
Health Special Risk, Inc.
P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free: (866) 409-5734

School District: MIAMI DADE COUNTY SCHOOLS
City and State: MIAMI, FL
School Name: NORTH MIAMI BEACH SHS
Policy Number: 2012201912

FOR ***HSR*** USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART I - POLICYHOLDER'S REPORT

1. Claimaint's Name (injured/ill person)	2. Social Security Number	3. Gender	4. Date of Birth (mm/dd/yyyy)	5. E-Mail
[redacted]		◉ M ○ F	07/28/1998	derrickbeauchamp@ymail.com

6. Address of Injured/Ill person	7. Best Contact Phone Number (include area code)
[redacted] St. , Miami, FL	305[redacted]5

8. Parent/Legal Guardian Name, Address	9. Best Contact Phone Number (include area code)
[redacted] - [redacted] St. , Miami, FL	305[redacted]5

10. Date of Accident/Illness (mm/dd/yyyy)	11. Time of Accident (hh:mm)	12. Place where Accident Occurred	13. Date of First Treatment (mm/dd/yyyy)
	12 : 00 ◉ a.m. ○ p.m.		

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.)	Did Injury Result in Death? ○ Yes ◉ No

17. Describe How Accident Occurred or the Nature of the Illness - Give all possible details

18. Which Best Describes the Activity:	☐ During lunch hour	☐ Athletic period
☐ Play or practice of interscholastic sports	☐ In school bus	☐ On school property during school hours
☐ Not school related	☐ School sponsored field trip	☐ School sponsored activity during school hours
☐ P.E. class	☐ Traveling to/from school	☐ A spectator

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?
Signature of Parent/Legal Guardian: Date: 07/26/2012	Name of School Official *Last 4 digits of SSN Date: 07/26/2012
	* serves as electronic signature

PART II - OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ○ Yes ◉ No

If Yes, name of insurance company		Policy #	
Name of insurance company		Policy #	
If applicable, claimant's primary employer name, address, and phone number			
If applicable, mother's primary employer name, address, and phone number			
If applicable, father's primary employer name, address, and phone number			

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse ***HEALTH SPECIAL RISK, INC.***, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian: Date: 07/26/2012

PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim.

SIGNATURE		DATE	07/26/2012

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE		DATE	07/26/2012

Click here to save your data and submit the completed form later.

SAVE Without Submitting | Submit | Reset | CANCEL

Click here to submit the completed form to HSR.

Instructions Fraud Statements

K-12 Fast Track

List of Existing Claims					Create New Claim
Action	**Claimant**	**Date Created**	**Last Update**	**Date Submitted**	**Status**
View/Print	joe & student	04/06/2012	04/06/2012	04/06/2012	Submitted - Pending
Edit | Del	asdasd & asda	04/06/2012	04/06/2012		NOT Submiited - Editing

If you have submitted at least one claim, your Claims page will display a list of those claims. You cannot edit a submitted claims, but you can **View** or **Print** it. Saved claims that have NOT been submitted can be **Edit**ed or **Del**eted.

Instructions Fraud Statements

t Access or Access Maintenance? Contact a District-Level Official.

Go!

Please address all questions/comments to:

HSR, Client Relations [Attn: Cassandra]
(972) 512-5660