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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.



STUDENT CLAIM FORM

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

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.



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

School District:

City and State:

School Name:

Policy Number:

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

PART I - POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person) <input type="text" value="██████████"/>		2. Social Security Number <input type="text" value=""/>		3. Gender <input checked="" type="radio"/> M <input type="radio"/> F		4. Date of Birth (mm/dd/yyyy) <input type="text" value="07/28/1998"/>		5. E-Mail <input type="text" value="derrickbeauchamp@ymail.com"/>	
6. Address of Injured/Ill person <input type="text" value="██████████ St, Miami, FL"/>				7. Best Contact Phone Number (include area code) <input type="text" value="305-██████-5"/>					
8. Parent/Legal Guardian Name, Address <input type="text" value="██████████ - ██████████ St, Miami, FL"/>				9. Best Contact Phone Number (include area code) <input type="text" value="305-██████-5"/>					
10. Date of Accident/Illness (mm/dd/yyyy) <input type="text" value=""/>		11. Time of Accident (hh:mm) <input type="text" value="12"/> : <input type="text" value="00"/> <input checked="" type="radio"/> a.m. <input type="radio"/> p.m.		12. Place where Accident Occurred <input type="text" value=""/>			13. Date of First Treatment (mm/dd/yyyy) <input type="text" value=""/>		
Dental Claims		14. Indicate which Teeth were Involved in the Accident <input type="text" value=""/>			15. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial				
16. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.) <input type="text" value=""/>								Did Injury Result in Death? <input type="radio"/> Yes <input checked="" type="radio"/> No	
17. Describe How Accident Occurred or the Nature of the Illness - Give all possible details <input type="text" value=""/>									

18. Which Best Describes the Activity:		
<input type="checkbox"/> Play or practice of interscholastic sports	<input type="checkbox"/> During lunch hour	<input type="checkbox"/> Athletic period
<input type="checkbox"/> Not school related	<input type="checkbox"/> In school bus	<input type="checkbox"/> On school property during school hours
<input type="checkbox"/> P.E. class	<input type="checkbox"/> School sponsored field trip	<input type="checkbox"/> School sponsored activity during school hours
	<input type="checkbox"/> Traveling to/from school	<input type="checkbox"/> A spectator
19. Name of Person Supervising the Activity <input type="text"/>		20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport? <input type="text"/>
Signature of Parent/Legal Guardian: <input type="text"/> Date: <input type="text" value="07/26/2012"/>		Name of School Official <input type="text"/> *Last 4 digits of SSN <input type="text"/> Date: <input type="text" value="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	<input type="text"/>	Policy #	<input type="text"/>
Name of insurance company	<input type="text"/>	Policy #	<input type="text"/>
If applicable, claimant's primary employer name, address, and phone number	<input type="text"/>		
If applicable, mother's primary employer name, address, and phone number	<input type="text"/>		
If applicable, father's primary employer name, address, and phone number	<input type="text"/>		

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:

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	<input type="text"/>	DATE	<input type="text" value="07/26/2012"/>
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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	<input type="text"/>	DATE	<input type="text" value="07/26/2012"/>
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Click here to save your data and submit the completed form later.

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Click here to submit the completed form to HSR.

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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 Submitted - Editing

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

Please address all questions/comments to:

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

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 **Edited** or **Deleted**.