STUDENT INSURANCE
A VENBROOK COMPANY

Student and Athlete Accident Medical Insurance Claims Processing Guide

Rancho Santiago CCD ➢ Effective Date: **08/01/2024**

Santa Ana College ➢ Policy Number: **1850VC**
Santiago Canyon College ➢ Policy Number: **1850VD**

Submission of Completed Claim & HIPPA Forms

- ✓ Claims@studentinsuranceusa.com
- ✓ Fax to (310)-826-1601

Day to day claims or policy assistance call or email Account Manager:
Leslie Hernandez 310-826-5688 Leslie@studentinsuranceusa.com
Emergency and after hours communication text, call or email Vice President:
Kimberly Rowan at 818-447-8098 Kimberly@studentinsuranceusa.com

Students and athletes sustain injuries during class, practice, conditioning or competition. The cost of medical care can be expensive, and the billing process can be confusing. The college accident insurance policy is in place to help cover accident related expenses.

However, the cost of medical care for injuries is a shared cost, and going through the claims process is a shared responsibility between the health care providers, student/athlete and parents all play a role in providing and making available accurate information and documentation that is shared with insurance companies to ensure claims can be processed.

This guide will help explain what is needed for a successful claim process.

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Anthem BlueCross

BASIC COVERAGE LIMITS

Per Accident Deductibles:	**$0.00** **$0.00**	Student, Class II Athletes Class I Athletes
Co-Insurance Percentage:	100%	PPO
Per Accident Maximum	$25,000.00 $50,000.00 $500.00 $2,000.00 $2,000.00 $25,000.00	Athletes Students Emergency Illness Benefit Dental Maximum Rental Durable Medical Equipment Expanded Medical/Intercollegiate Athletes
AD&D Benefits	Loss of Life Dismemberment	$10,000.00 Single: $1,000.00/Double: $5,000.00

When a student/athletic injury occurs a claim must be filed using the S.A.I.N (Student Accident Insurance Network) Policy forms and submitted to STUDENT INSURANCE within 90 days of injury, and medical treatment must occur within 120 days from the date of injury.

Basic Coverage

Policy Term	1 Year Incurring Period
Insuring Company	Anthem Blue Cross
Coverage Limits Sports	$25,000
Coverage Limits Non Sport	$50,000

Catastrophic Coverage

Policy Term	10 Year Incurring Period
Insuring Company	Philadelphia
Coverage Limits	$1,000,000

How to Find In-Network Providers for Anthem Blue Cross:

1) Go to https://www.studentinsuranceusa.com
2) Select your College
3) Select Student/Athlete Accident Medical Plan
4) Select Provider Finder

Important Information:

- The Anthem Basic policy is only valid for 52-weeks from the date of injury.
- Initial medical treatment **must** occur within 120 days from the date of injury.
- Claim form must be submitted to Student Insurance within 90 days of injury.
- Catastrophic coverage only valid after basic limit met.
- Expanded Medical benefit only available for athletes.

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Key terms used in this policy:

Expanded Medical Coverage in the case of an athlete or a high-risk student, it is also a physiological malfunction, such as athlete's heart, heat stroke, heart block, embolism, stress fracture, et cetera, which may not be the direct result of an accidental injury, but, satisfactory evidence is provided to Anthem that the physical malfunction occurred while the athlete was participating in intercollegiate athletics or the high risk student was participating in a police or fire academy program. The physical harm or physical malfunction must have occurred at an identifiable time and place. Accidental injury does not, otherwise, include illness or infection, except infection of a cut or wound.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. In the case of an athlete or a high risk student, it is also a physiological malfunction, such as athlete's heart, heat stroke, heart block, embolism, stress fracture, et cetera, which may not be the direct result of an accidental injury, but, satisfactory evidence is provided to Anthem Blue Cross Life and Health that the physical malfunction occurred while the athlete was participating in intercollegiate athletics or the high risk student was participating in a police or fire academy program. The physical harm, disability, or physical malfunction must have occurred at an identifiable time and place. Accidental injury does not, otherwise, include illness or infection, except infection of a cut or wound.

Class 1 and Class 2 athletic activities are determined by the sport the athlete is actually training, practicing or participating in, under supervision of an authorized representative of the college, including club activities, as follows:

- **Class 1** - football, soccer, wrestling, surfing, gymnastics, and skiing.
- **Class 2** - all other sports.

Club Activities are those activities or events normally performed, or staged, by a club approved by the college board and supervised by the college. The activities or events performed, or staged, by the club may be athletic activities or non-athletic activities.

Emergency illness is an emergency which does not involve an accidental injury.

Official visitor, activities, and Auditing Students are:

- Conducting research or addressing the faculty and/or students;
- In the case of a child, attending "Mommy and me" classes with their student parent . These activities must take place on college grounds, in college leased or rented buildings, on or off campus, during the time classes are college authorized and calendared, and while at other locations as required by college sponsored and supervised activities.

2024-2025
Student /Athlete Accident Insurance Claims Filing Instructions

The College has a Student Accident Insurance Excess policy in the event a student becomes injured and requires medical treatment. An Injury Claim Form must be completed and signed by the student and the designated college official before submitting it to STUDENT INSURANCE.
Claim & HIPAA Forms can be located under the college name on the Student Insurance website.
www.studentinsuranceusa.com or by contacting a STUDENT INSURANCE representative at 310-826-5688

Please be advised that this excess coverage is secondary in most situations to all other valid and collectible insurance plans. Each student must provide their health insurance information to each medical provider at the time of treatment, along with the Student Accident insurance claim form. This policy is designed to cover any remaining balances or expenses related to a covered injury/accident that are not covered by the student or athlete's primary insurance (including co-pays, deductibles, coinsurance, etc.)
To ensure that claims are paid under the Student Accident Insurance Policy, students must give the completed claim form to each medical provider seen for medical treatment and service related to their accidental injury.

This card is for identification purposes only and does not guarantee benefits

Student Accident Insurance Network

Rancho Santiago CCD

Santa Ana College — Policy # 1850VC
Santiago Canyon College — Policy # 1850VD

Group # **SAIN**

RANCHO SANTIAGO
Community College District

Policy Effective Date: **8/1/2024**
Benefits Effective 52 Weeks from the Date of Injury Treatment must be initiated within 120 days of injury date

NO Deductible

Coverage Limit Per Claim: $25,000 per Athletic Accident
$50,000 Student None Athletic Accident

Excess Coverage

Eligibility is subject to change
This card is for identification purposes only and does not guarantee benefits.

Claims submissions can be Emailed or Faxed to Student Insurance at:
claims@studentinsuranceusa.com | 310-826-1601

Members & College Staff Call: **310-826-5688 | 800-367-5830**
Medical Providers Call: **866-811-7946**
Reference: **SAIN College Accident Program**

NO Prior Authorization Needed

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Anthem BlueCross

Visit Student Insurance for more information at www.studentinsuranceusa.com

STUDENT INSURANCE
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Contact Information for Student & Athletic Accident Injuries

For Claims Questions Contact:

Student Insurance College Claims Department
claims@studentinsuranceusa.com
Phone: (310) 826-5688 or (800) 367-5830
Fax: (310) 826-1601

Claim Submittal for College Officials and Students/Athletes:

Email or fax all completed Claim & HIPAA forms, and Itemized bills (if applicable) to:

claims@studentinsuranceusa.com
or
Fax: (310) 826-1601

Claim Submittal Instructions for Medical Providers ONLY

Fax or US postal mail completed claim form with all bills
(HCFA1500 / UB04) and Primary EOB's, to:

Anthem Blue Cross
Student Health Claims Dept.
Attn: Claims Manager
21215 Burbank Blvd.
Woodland Hills, CA 91367
Priority Fax: (855) 396-8418
Phone: (855) 396-8418

****NOTE**** USPS is the only acceptance of medical billing for the Student Division of ANTHEM Blue Cross. Electronic Billing is not acceptable with this policy.

Understanding Claims Filing

Primary Insurance

A primary policy is coverage that a parent may have through their place of employment, or a policy purchased on the Affordable Care Act exchange, and in some cases a medical health insurance plan provided by the school. These are all considered "primary," This means injuries that occur at the college, at a supervised college event, or during a sport activity will first be handled through that primary insurance.

However, there are certain types of insurance that have limitations, especially when it comes to intercollegiate sports injuries. This is why you must provide all insurance information regardless what it may or may not cover.

NOT Primary Insurance

- **Government-Sponsored Insurance (TriCare, Medicaid, etc.):** These plans do not pay as primary insurance when the school has accident insurance.
- **Student Health Insurance Plan (SHIP):** SHIPs may specifically state that injuries related to intercollegiate athletics are not covered. All other injuries may be paid as primary.
- **"Religious Ministry" Plans:** Ministry plans often exclude intercollegiate athletics, or rely on a discretionary claim process, coverage may not meet institution primary insurance requirements.

School Sponsored Accident Coverage

In the cases, of no primary insurance, the student/athlete accident insurance policy will pay as primary for accident related injuries, within the limits of coverage under the schools policy.
The institutions accident policy is for all students including intercollegiate sports.

This is an "**accident-only**" plan, meaning that illnesses are not covered.

The Anthem policy provides payment of 100% of allowed charges incurred within 365 days following the date of injury. Treatment by a license medical doctor must be sought within 90 days of the accident.
Injuries must be reported to the appropriate staff or faculty for documentation of a claim prior to treatment.

A copy of the SAIN insurance policy is on file at the college for review.

Documents Needed to **Start** a Claim

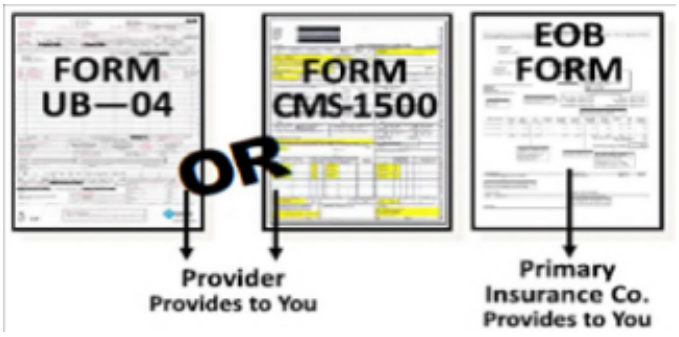
Claim Form: Must be submitted by the college with complete details surrounding the injury. The claim form should be submitted as soon as possible. However, there is a 90 day grace period.

HIPAA Form: Must be submitted with every completed claim form so that anyone at the college or Student Insurance can assist with treatment arrangements, bills, appointments and any other medical information needs.

These 2 documents must be given to the student and once completed, email to Student Insurance at Claims@studentinsuranceusa.com for processing. If one of the documents is missing, an Account Manager will send an email, or letter requesting the needed information from the student directly. If the student cannot be reached an email will be sent to the college. It is very important to respond and keep the lines of communication open to avoid a claim being denied or sent to collections by a provider.

Documents Needed to **Pay** Claims

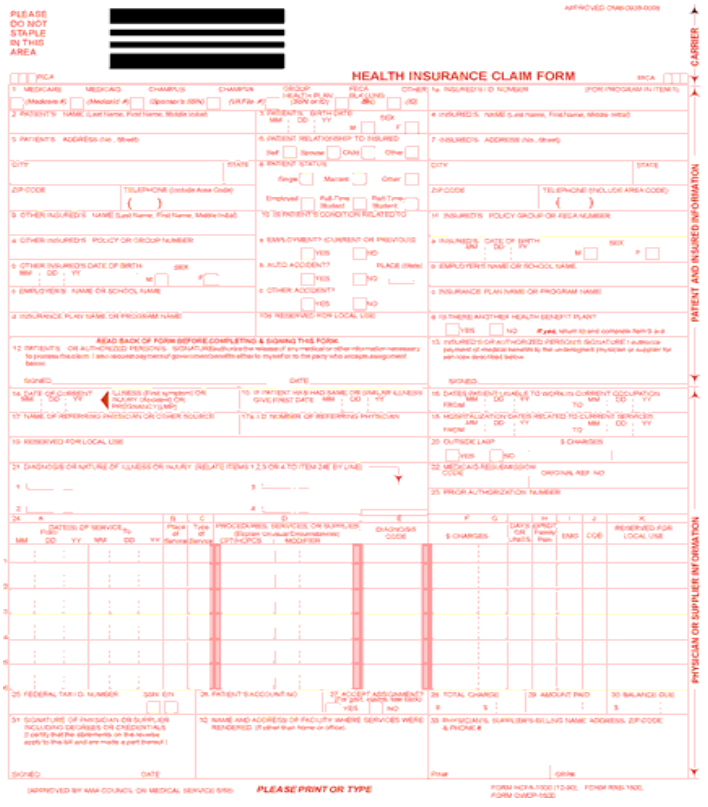
1. **Fully Itemized Bill:** Typically submitted by health care providers. In some cases, bills will be sent to primary policy holder (student-athlete or parent), in this case send a copy to claims@studentinsuranceusa.com and a Student Insurance Representative will handle it.
   The bill must contain the actual diagnosis codes and amount charged for each treatment. This type of bills are referred to as: **HCFA-1500 for a doctor's report, or UB-04 for a hospital report.**
2. **Balance Due Bill:** A statement or receipt that only shows the amount billed will **NOT** be paid
3. **Explanation of Benefits (EOB):** A summary generated by an insurance company explaining how a claim was processed. It will include the insured's name, date of treatment, amount charged by the provider, the amounts covered and not covered under the insurance plan, and possibly an amount that the student/patient is responsible for.



If you receive any bills, email them to claims@studentinsuranceusa.com

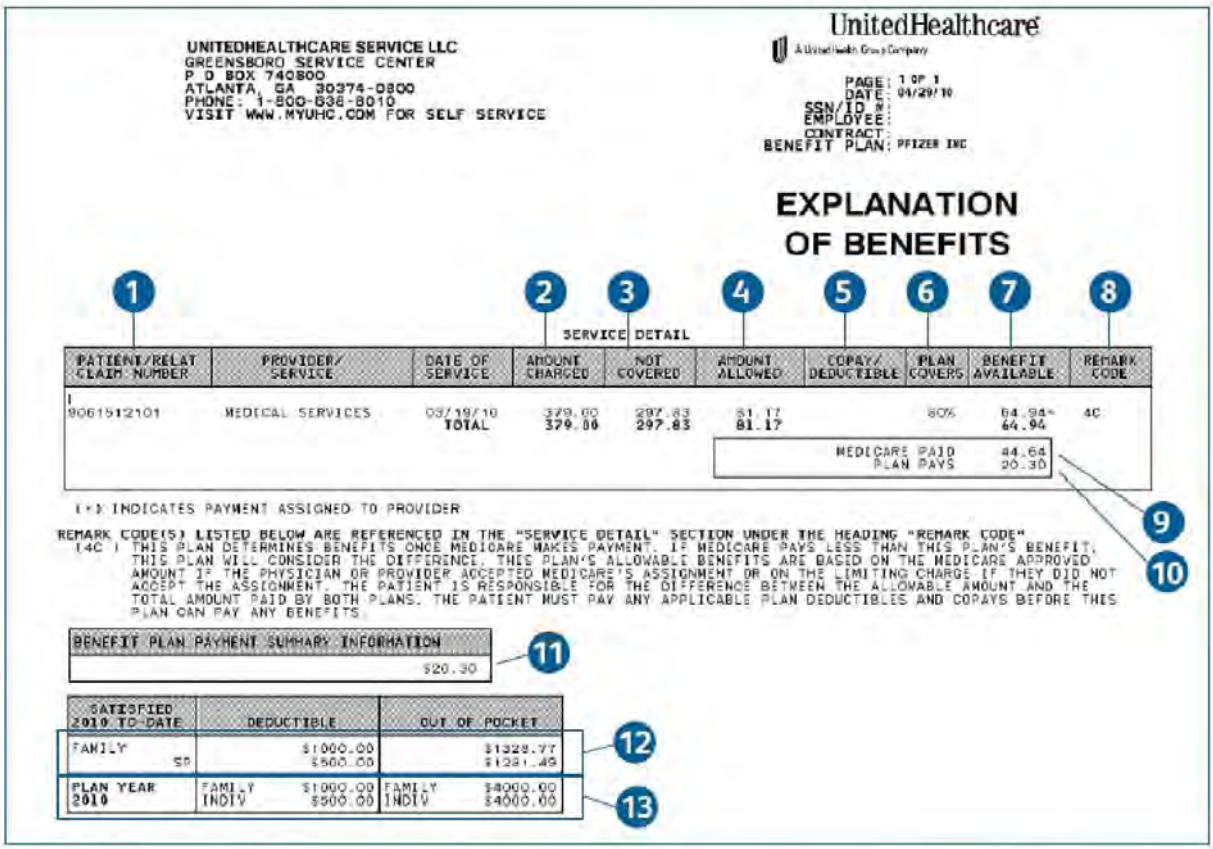
If you receive any ills, email them to claims@studentinsuranceusa.com

SAMPLE HCFA 1500



SAMPLE UB-04

SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	2 AMOUNT CHARGED	3 NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
I 9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE		OUT OF POCKET	
FAMILY	$1000.00		$1328.77	
SP	$500.00		$1281.49	
PLAN YEAR 2010	FAMILY	$1000.00	FAMILY	$4000.00
	INDIV	$500.00	INDIV	$4000.00

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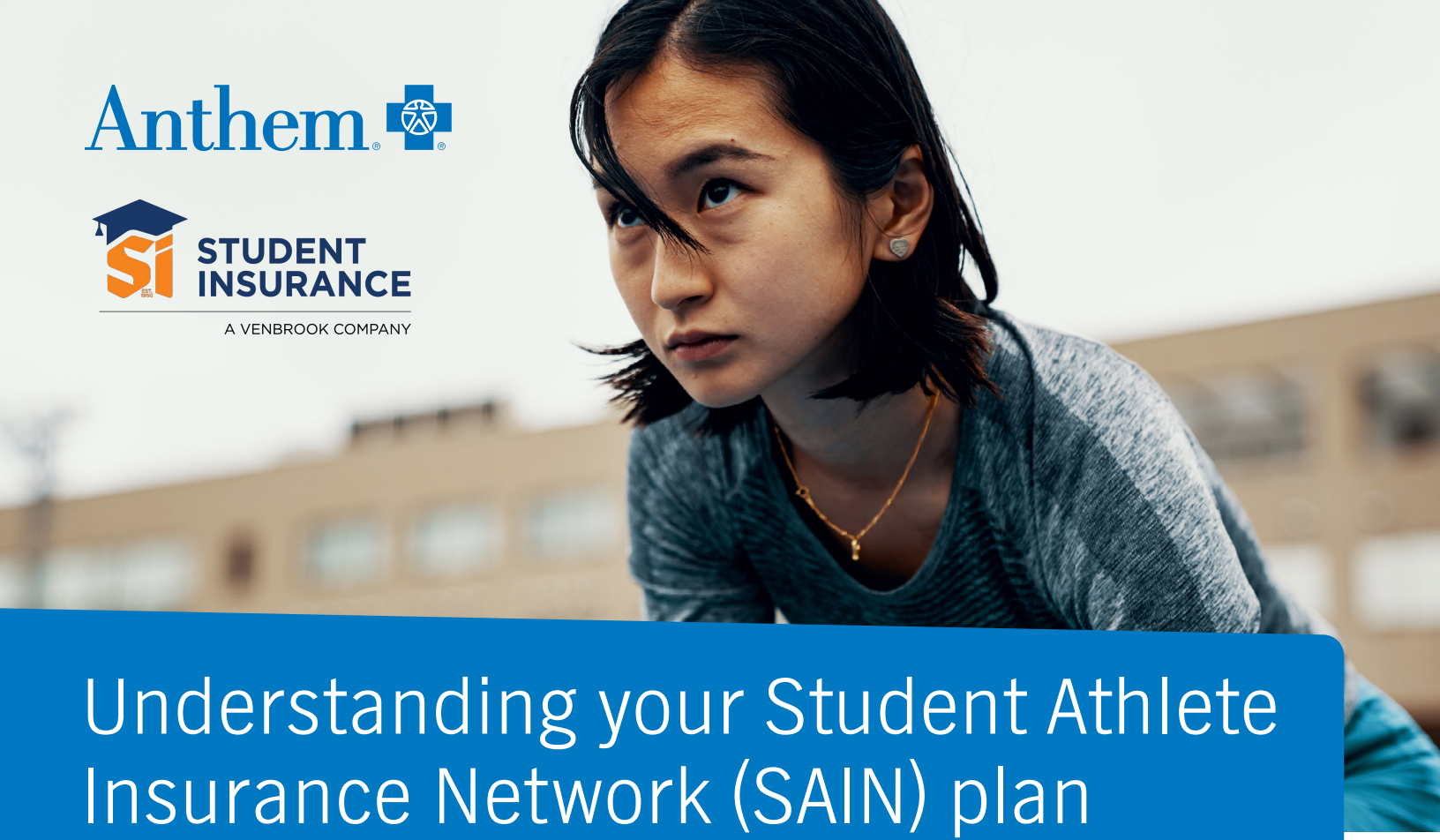

Understanding your Student Athlete Insurance Network (SAIN) plan

Welcome to your SAIN benefits. As a student, you can rest assured that you're covered if you have an accident or injury. Your SAIN plan gives you access to the care you need to recover and return to school and sports.

Who is eligible for coverage?

Student-athletes who are:

- Enrolled and registered in college, **and**
- Participating in or attending any regularly scheduled practice or competition supervised by an authorized representative of the college, **or**
- Traveling directly to and from practice or competition with other members as a group, only if travel is supervised by an authorized representative of the college.

Other students who are:

- Enrolled and registered in college, **and**
- Attending regularly scheduled classes at college, **or**
- Attending supervised and administratively approved college activities, including clubs or college-supervised travel to and from college-sponsored events.

Children of students

- In a child care facility on the college campus, provided by the college, **or**
- Attending a mommy and me class provided by the college with their student-parent.

High-risk students

- Students attending fire or police academies associated with the college who have paid the appropriate premiums.

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If you have an accident

Immediately report it to your college authority, instructor, coach, athletic trainer, or the college health center, if one is available. An accident report is required to validate an insurance claim. Contact the health office or athletic trainer for reporting forms and information.

Filing a claim

Be sure to send a written notice of your claim **within 120 days** of the accident or injury. Include any itemized bills in the claim. Bills submitted more than 12 months after the date of service will be denied.

Your SAIN plan is secondary to other health plans

If you have another health plan, your other plan will serve as the primary insurer, except where state or federal law requires.

Benefit deductibles

Per-accident deductible

Student activities deductible	$0
Class I athletes activities deductible[1]	$0
Class II athletes activities deductible[1]	$0
Child of student in child-care facility activities deductible	$0

Your coverage

For an accident

- ✓ One hundred percent of excess medical costs are covered once your deductible has been met when you stay in the preferred provider organization (PPO) network.[2]
- ✓ **Only** Fifty percent of the maximum allowed amount is covered when you go outside the PPO network.
- ✓ The maximum medical benefit amount for student-athletes is $25,000.
- ✓ The maximum medical benefit for all other students and their children is $50,000.

Benefits are covered for 52 weeks from the date of the accident. The first covered treatment must be within 120 days of the injury.

For emergency illnesses

- ✓ Up to $500 for all emergency illness per semester.[3]

What is not covered

- × Services or supplies that are not medically needed.
- × Any amount beyond the maximum allowed for each accident or emergency illness.

Please contact your Student Insurance Representative To review the list of exclusions, in your master policy.

To find out more about your SAIN plan, contact your college or visit **studentinsuranceusa.com**.

S.A.I.N.
Student & Athlete Insurance Network

HIPAA Individual Authorization

Anthem

Instructions: Please complete the form in its entirety and include as much information as possible.

Individual last name	First name		M.I.	Group ID no.
College name	Social Security no. (optional)	Date of birth (MMDDYY)	Daytime phone no. (with area code)	
Individual street address	City		State	ZIP code

Part A: I authorize the following person or types of people to disclose my information:

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates and agents.

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

S.A.I.N. Health Group plan representatives

Athletic Personnel and/or Director of Nursing – Name: _____

Chief Business Official and/or Administrator – Name: _____

Name and relationship to the individual: _____

Part C: I authorize the following information to be used or disclosed on my behalf:

Only limited information may be disclosed (check all applicable blocks below):

Limited Information:
- ☑ Benefits & coverage
- ☑ Billing
- ☑ Claims & payment
- ☑ Diagnosis & procedure
- ☑ Eligibility & enrollment
- ☑ Medical records (excludes psychotherapy notes[1])
- ☑ Physician & hospital
- ☑ Treatment
- ☑ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all blocks that apply to you):

☐ All sensitive information **OR** Just information about topics checked below:

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse[2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request

☐ For the following purposes: **Auditing, enrollment, billing, financial analysis, stop-loss/reinsurance, and benefit analysis.**

Part E: Expiration date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- The date my coverage ends (only if disclosure requested by insurance company)
- One year from the signature date below
- Upon the following date, event or condition (within the one year time frame): ____ (MMDDYY)
- Accident date: ____ (MMDDYY)

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, enrollment or eligibility for benefits on signing this authorization. I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Individual signature	Date (MMDDYY)
X	

Designated legal representative/guardian

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name)	Legal relationship to individual

Individual signature	Date (MMDDYY)
X	

1 **Note:** This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.

2 I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please keep a copy of this form for your records and return the completed form to:

Student Insurance
6320 Canoga Ave., 12th Floor
Woodland Hills, CA 91367

Email to: claims@studentinsuranceusa.com
Phone: 1-310-826-5688
Fax to: 1-310-826-1601

Reset Form | Save and Print

SUBMIT ONLINE

Corporate Privacy has approved this form and it is an accepted HIPAA Authorization for the S.A.I.N. (Student Athlete Insurance Network) Group. 1/2017

Student & Athlete Insurance Network Accident Claim Verification Form

Claim control no. for Anthem Blue Cross use only

Providers mail with bills to:
Student Health Claims Dept.
Attn: Claims Manager
21215 Burbank Blvd.
Woodland Hills, CA 91367
Reference S.A.I.N. Program when calling toll free: 1-866-811-7946
For priority issues please fax to: 1-855-396-8418

Anthem

This policy is secondary coverage to all other policies, except as required by state or federal law.

To be completed by student or athlete

Student last name	First name	M.I.	Birthdate (MMDDYY)

Street address	City	State	ZIP code

Phone no.	Email address

1. Give full description of injury from which you are now suffering. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred.
Date: ____ (MMDDYY) Time: _____ ☐ a.m. ☐ p.m.

3. When did you first consult a physician for this condition?
Date: ____ (MMDDYY)

4. Do you have other insurance? ☐ Yes ☐ No If yes, complete the following.
Other insurance coverage is through: ☐ Parent ☐ Self ☐ Spouse
Type of coverage: ☐ Individual ☐ Through employer
Type of plan: ☐ HMO ☐ Other: _____
Group/policy no.: _____
Policyholder name: _____
Employer name (if applicable): _____
Insurance company name: _____
Insurance company address: _____

5. Are you an international student?
☐ Yes ☐ No

Sign your full name X	Date (MMDDYY)

On-Campus accidents — To be completed by college official

College name	Group/policy no.	Time classes/activity began on date of injury: Time: _____ ☐ a.m. ☐ p.m.

Did accident occur (check yes or no)	Yes	No		Yes	No
a. While claimant was supervised?	☐	☐	e. During intercollegiate practice?	☐	☐
b. During sponsored activity?	☐	☐	f. During intercollegiate competition?	☐	☐
c. During programmed hours?	☐	☐	g. While traveling to or from a regularly scheduled activity in a supervised group?	☐	☐
d. On school premises?	☐	☐			

I hereby certify that the statements made above are correct to the best of my knowledge and belief and that the above named claimant was insured hereunder at the time of the accident;

College official signature X	Printed name	Title	Date (MMDDYY)

Intercollegiate athletic accidents — To be completed by athletic official

Intercollegiate sport name	Position played	Did injury occur during non-traditional sports session? ☐ Yes ☐ No	☐ Practice ☐ Competition

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision on: → Date (MMDDYY)

Athletic official signature X	Printed name	Title	Date (MMDDYY)

Athletic and on campus accidents – To be completed by college official

Name of class or P.E.: _____

Authorization to pay benefits to provider

I authorize payment of medical payments to physician or supplier for services described for the attached statements:

Student/athlete signature X	Date (MMDDYY)

SUBMIT ONLINE Reset Form Save and Print

To the student

- Use this form each time you visit a physician or hospital as a result of an accidental injury incurred while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **ONLY** use this form after the college has properly authorized and completed their portion.
- Give this form to the physician or hospital so they may properly submit the claim to Anthem Blue Cross.
- Copay Reimbursement – may be considered **only if** (1) a HCFA 1500 billing or UB-04 billing is submitted with a copy of the primary insurance Explanation of Benefits (EOB), and (2) a receipt indicating the amount of the copay. Balance due bills or statements are not acceptable documents for processing of payments.

To the provider

- This plan covers the student for accidental injury while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **Please check to see that the appropriate college representatives have completed their portion before submitting the claim.**
- To insure prompt payment, please attach all (UB-04 and/or HCFA 1500) billings to this form and submit to:

  Student Health Claims Dept.
  Attn: Claims Manager
  21215 Burbank Blvd.
  Woodland Hills, CA 91367

  Reference S.A.I.N. Program when calling toll free: 1-866-811-7946
  For priority issues please fax to: 1-855-396-8418

Balance due bills or statements are not acceptable documents for processing of payments.

- Electronic Billing is **not an option** with this program. This program does not accept 'Electronic Billing.' All bills must be submitted via USPS with a copy of the Claim Form attached.
- **Colleges send HIPAA and Claim Forms to:**
  Student Insurance
  6320 Canoga Ave., 12th Floor
  Woodland Hills, CA 91367
  Email to: claims@studentinsuranceusa.com
  Fax: 1-310-826-1601

  SUBMIT ONLINE
- For additional information, please contact Student Insurance Information at 1-310-826-5688 or Anthem Blue Cross at 1-866-811-7946.