

**ACCIDENT & SICKNESS INSURANCE CLAIM FORM**

**GROUP NAME:** YORK COLLEGE OF PA **POLICY NUMBER:** AW000258 **DATE:** \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Current Home Address \_\_\_\_\_  
Number and Street City State Zip Code Phone Number

Name of Dependent \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Date of injury or beginning of sickness \_\_\_\_\_ When was physician first consulted? \_\_\_\_\_

2. Work related injury?  Yes  No Injury due to motor vehicle accident?  Yes  No

3. If injury, describe how and where accident occurred \_\_\_\_\_  
\_\_\_\_\_

4. Nature of injury or sickness \_\_\_\_\_

5. List all medications prescribed for this injury/sickness \_\_\_\_\_

6. Did injury occur during practice or play of sports?  Yes  No  
If yes, please check one of the following:  Intramural/Club Name of Sport \_\_\_\_\_  
 Other \_\_\_\_\_  Intercollegiate Signature of Athletic Trainer \_\_\_\_\_

7. Have you suffered same or similar condition before?  Yes  No If yes, and you were previously treated, dates treated: \_\_\_\_\_  
\_\_\_\_\_  
Name and address of physician who treated you: \_\_\_\_\_

8. If hospitalized at that time, date confined to hospital: \_\_\_\_\_  
Name and address of hospital: \_\_\_\_\_

Do you have other insurance that covers your condition (group, individual, automobile, medical, or liability)?  Yes  No

If yes, who is the Holder of Policy?  Self  Parent  Spouse Give name of Company \_\_\_\_\_

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone # of Insurance Company: \_\_\_\_\_

Parent's/Spouse's Name (Holder of Policy) \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN, AND OTHERS), UNLESS PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

**IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.**

**AUTHORIZATION: I hereby authorize Global Claims Administration, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.**

**SIGNATURE OF PARENT (OR CLAIMANT, IF ADULT)** \_\_\_\_\_ **DATE** \_\_\_\_\_

## IMPORTANT NOTICE

**Fraud Warning:** Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

**Notice to Arizona Claimants:** 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 the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Notice to California Claimants:** For your protection California law requires the following statement 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.

**Notice to Colorado Claimants:** It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

**Notice to Hawaii Claimants:** For your protection Hawaii Law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

**Notice to Kentucky 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 subjects such a person to criminal and civil penalties.

**Notice to Oklahoma Claimants:** 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.

**Notice to Pennsylvania 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 subjects such a person to criminal and civil penalties.

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

## HOW TO FILE A CLAIM

Please follow these instructions:

- Complete front of claim form, in full;
- Sign Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to Administrator with itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable)

All itemized bills must include:

1. Patient's Name;
  2. Patient's Address;
  3. Diagnosis;
  4. Date of Service;
  5. Description of Service (CPT Coding);
  6. Medical Provider's Name, Address, Telephone Number, and Federal Tax ID Number
- A completed claim form must be submitted for each injury or sickness a student sustains.

**Keep copies of all claims forms, bills, and correspondence for your own records.**

**In order for benefits to be paid, claim forms must be filed within 90 days from the date of injury or sickness.**