National Union Fire Insurance Company of Pittsburgh, Pa.

COVERAGE VERIFIED

PLEASE PRINT ALL INFORMATION

MAIL TO:
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
1-800-468-4343

CLAIM FORM

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

SPECIAL NOTICE: 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.

PART 1 – MUST BE COMPLETED AND SIGNED

Name of School | Policy Number | Birth Date

Insured's Name: LAST NAME | FIRST NAME | M.I | INSURED'S SOCIAL SECURITY # | PHONE

Present Address: NO. AND STREET | CITY OR TOWN | STATE | ZIP + 4

Home Address: NO. AND STREET | CITY OR TOWN | STATE | ZIP + 4

If claim for dependent, give dependent's name ______ , relationship to insured ______ D.O.B. ______

MUST BE COMPLETED

Are you covered (as an insured or dependent) by any other hospital and/or medical plan? ☐ Yes Insured ☐ Yes Dependent ☐ No

If yes, please check one: ☐ Group ☐ Individual ☐ Automobile/Medical

If yes, also indicate name and policy number of insurance company.

Name of Insured: ______ Policy #/Group #: ______ I.D. # ______ Company ______

Have you filed a claim with the above company? ☐ Yes ☐ No

Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.

Name and Address of Employer of:

☐ Insured, if employed ______

☐ Spouse, if insured is married ______

1. Date of accident or sickness		Date of first treatment.
2. Nature of sickness or injury.		
3. If injury, describe how and when accident occurred and indicate if work related		
*4. If injured in practice or play or sport, indicate which sport.		Check One: ☐ Club ☐ Intercollegiate ☐ Other
5. Have you previously been troubled with this condition?	☐ Yes ☐ No Date ______	
6. Give name of all other physicians consulted		
7. Hospitalized? If so, where and what dates	Where?	From: ______ To: ______
8. Health Center referral?	☐ Yes ☐ No	If yes, attach referral to claims form. If no, please explain ______

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician and others), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED

*** IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL**

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision ______ DATE

Signature of College Official ______ **Title** ______ **Date** ______

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit *(while my claim is pending)* the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization *(one or which will be given to me by the Company upon my request)* will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature ______ **Date** ______

If Authorized Representative, Relationship to Patient ______

STREET | CITY | STATE | Zip + 4

PART II – ATTENDING PHYSICIAN'S STATEMENT

AUTHORIZATION: I hereby authorize the Company, or the designated claims administrator to inspect or secure copies of case history records, laboratory reports, diagnoses, prognoses, and any data covering this or other confinements and disabilities.

DOCTOR, PLEASE SIGN ______________________________ **DATE** ______________

EACH DOCTOR'S BILL ATTACHED MUST BEAR THE DOCTOR'S I.D. OR SOCIAL SECURITY NUMBER

1. Nature of sickness or injury. Describe any complications	
2. If fracture or dislocation, state whether reduced or immobilized. If fractures of long bones, state whether fracture is though shaft or extremity. Was it confirmed by X-ray?	☐ Yes ☐ No
3. When did symptoms first appear or accident happen?	Date ______________ , ______________
4. When did patient first consult you for this condition?	Date ______________ , ______________
5. Has patient ever had same or similar condition? If yes, state when and describe.	☐ Yes ☐ No Date ______________ , ______________
6. Describe any other disease or infirmity affecting present condition.	
7. Nature of any surgical or obstetrical procedure. Describe fully. Include CPT Code. Where and when performed?	Date ______________ If in hospital, in patient ☐ out-patient ☐
8. Give dates of treatment.	
9 Is condition a result of or in any way connected with pregnancy?	☐ Yes ☐ No Inception date of pregnancy: ______________
10. Is patient still under your care for this condition? If discharged, give date.	☐ Yes ☐ No Discharge date ______________ , ______________
11. If patient hospitalized, give name and address of hospital.	Hospital City State Date admitted ______ , ______ Date discharged ______ , ______
12. Did you file this claim with any other Insurance Company? If yes, indicate name and address of Company.	Name ______________ ☐ Yes ☐ No Address

Signed: ______________ **Degree** ______________ **Date** ______________

S.S # ______________ **THIS MUST BE INCLUDED** **Phone #** ______________

ADDRESS: ______________________________

STREET CITY STATE ZIP + 4

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITOIN TO THOSE ABOVE

1. State exactly which teeth were involved in the accident and indicate them on chart

____

____

2. Describe exact nature of injury.

____

____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

3. Describe condition of injured teeth prior to accident:

☐ Whole, sound and natural

☐ Filled ☐ Capped ☐ Artificial

4. Comments:

____

____

____

IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment accompanied by all bills incurred to that date.