USA Volleyball
MEDICAL CLAIM FORM

Send this form to:
American Specialty
142 N. Main St.
Roanoke, IN 46783
FAX: 260-673-1189

This form to be completed whenever a medical claim results from an injury incurred at USA Volleyball sanctioned events.
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY

NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE NUMBER ( )	OCCUPATION

USA VOLLEYBALL PARTICIPANT #:	DATE & TIME OF ACCIDENT: _____/_____/_____ _____ ___AM __PM

INJURED PARTY WAS:
☐ PARTICIPANT ☐ COACH ☐ OFFICIAL ☐ VOLUNTEER ☐ OTHER: _____

IF PARTICIPANT, MEMBERSHIP TYPE:
☐ JUNIOR MEMBER ☐ ADULT MEMBER ☐ NATIONAL OR HIGH PERFORMANCE TEAM MEMBER

REGIONAL ASSOCIATION NAME:	COACHES NAME:	PHONE #: ( )

NATURE OF INJURY

FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____

_____

B. DESCRIBE WHERE ACCIDENT HAPPENED: _____

_____

C. DESCRIBE HOW ACCIDENT HAPPENED: _____

_____

D. DID THE ACCIDENT OCCUR DURING:

☐ COMPETITION ☐ PRACTICE ☐ TRAVELING TO/FROM ☐ OTHER: _____

E. WITNESS NAME: _____ PHONE #: _____

IF INJURED PARTY IS A MINOR:

PARENT/GUARDIAN NAME: _____ HOME PHONE #: _____

EMPLOYER NAME: _____ WORK PHONE #: _____

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IF YES, NAME OF INSURANCE COMPANY	POLICY NUMBER

ADDRESS (Street) (City) (State) (Zip Code)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)	DATE

AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.	IF YES, SIGNATURE	DATE

I certify that the foregoing information is true and correct.	SIGNATURE	DATE

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.

2009-2010
USAVolleyball
MEDICAL CLAIM FILING INSTRUCTIONS

1. DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA VOLLEYBALL.
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital or other providers' standard insurance billing forms: HCFA from physician or UB 92 from Hospital. These forms must show the following:
    - Patients Name
    - Condition/Diagnosis
    - Type of Treatment
    - Date expense incurred
    - Charges
4. Your coverage is an excess policy unless there is no other insurance in place. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces or other coverage.
5. To expedite proper processing, submit form complete in full along with the above documents to the following address:

American Specialty
PO Box 459
Roanoke, IN 46783
Phone Number: 800-566-7941 or 260-673-1109
Fax Number: 260-673-1189

E-Mail Address: Adjuster: grudicel@amerspec.com

Important Claim Notice

California Residents: Caution: 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.

Colorado Residents: Caution: It is unlawful to knowingly provide false, incomplete, or misleading facts or 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Caution: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Caution: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland Residents: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: Caution: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Caution: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Caution: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon Residents: Caution: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Caution: 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 person to criminal and civil penalties.

Tennessee Residents: Caution: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Caution: 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.

Virginia Residents: Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

For All States Other Than Those Above: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

_____ _____

Signature of injured person (or parent/guardian if a minor) Date