MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

MCA ADMINISTRATORS, INC.

P.O. BOX 6540
HARRISBURG, PA 17112

ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS
UNDERWRITTEN BY: ACE AMERICAN INSURANCE COMPANY

CLAIM ASSISTANCE:
1-800-427-9308

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A. POLICY HOLDER

(1) Name of School District/College/Organization	Individual School/Team				(2) County
(3) Address of School: (Street)	(City)	(State)	(Zip)	(4) Area Code - Telephone #	(5) Date of Injury MO DAY YR
(6) Name of Injured Person	(7) Date of Birth MO DAY YR	(8) Social Security #	(9) Age	(10) Grade	(11) MALE ☐ FEMALE ☐
(12) Injury occurred: Practice ☐ Game ☐ P.E. ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐					(13) Type of Sport:
(14) Describe in detail HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.					
(15) What part of the body was injured: (Left or Right side if applicable)					(15a) Time of injury ____:____ a.m. ____:____ p.m.
(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐					
(17) Name of Supervisor (If different from organization official)					(18) Was he/she a witness to accident? Yes ☐ No ☐
(19) Signature of School or Organization Official				(20) Title of Official	(21) Date Signed MO DAY YR

PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

(1) Name of Mother/Father or Guardian	(2) Social Security #	(3) Relationship to insured	☐ Father ☐ Mother Guardian Self		
(4) Address (Number) Street (Lot or Apt. No.)	(5) City	(6) State	(7) Zip Code		
(8) Area Code – Home Telephone Number	(9) Father's work telephone ( ) _____ Mother's work telephone ( ) _____				
(10) Occupation of Father or Mother, Wife or Husband	(11) Place of Employment	(12) Address of Employer			
(13) Occupation of Self (if over age 18)	(14) Place of Employment	(15) Address of Employer			
(16) Do you have any other health and/or accident insurance plan (other than this plan?) Father: ☐ YES ☐ NO Mother: ☐ YES ☐ NO Husband: ☐ YES ☐ NO Wife: ☐ YES ☐ NO Self: ☐ YES ☐ NO					
(17) Is the injured person covered by other health and/or accident insurance plan? ☐ YES ☐ NO Effective Date MO DAY YR	(18) Name of other health and accident insurance company				
(19) Address of Insurance Company	(20) Policy Number	Phone #			

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, government agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administration to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the Policy identified above and that a copy of this Authorization shall be considered as valid as the original.
I agree that a photographic copy of this authorization shall be valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to intent to revoke.

Signature of Insured or Authorized Representative — Dated

Address

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

Date — Signature of Responsible Party or Student if 18 years old

Fraud 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.

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.

2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.

3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: MCA Administrators, Inc. for processing: paid receipts and/or balance due statements are not accepted.

4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

FRAUD WARNING

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 and subjects such person to criminal and civil penalties.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).

2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.

3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)

5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.