

A MAIL TO:
Maksin Management
P.O. Box 2647
Camden, NJ 08101-2647
1-877-775-5430

CLAIM FORM

COMPLETE IN DETAIL
TO ENSURE
PROMPT HANDLING

B COVERAGE VERIFIED

**PLEASE PRINT ALL
INFORMATION**

C SPECIAL NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

D PART 1 – MUST BE COMPLETED AND SIGNED

1 Name of School The University of the USA	2 Policy Number AIH0000000	3 Birth Date 01/01/01	
4 Insured's Name Doe, Jr. John A LAST NAME FIRST NAME M.I.	5 INSURED'S SOCIAL SECURITY # 000-00-0000	6 PHONE (555) 555-5555	
7 Present Address 123 Maple Street NO. AND STREET	Hometown CITY OR TOWN	NJ STATE	55555-5555 ZIP + 4
8 Home Address 123 Elm Street NO. AND STREET	Anywhere CITY OR TOWN	CO STATE	11111-1111 ZIP + 4
9 If claim for dependent, give dependent's name N/A		, relationship to insured _____ D.O.B. _____	

E MUST BE COMPLETED	1 Are you covered (as an insured or dependent) by any other hospital and/or medical plan? <input type="checkbox"/> Yes Insured <input checked="" type="checkbox"/> Yes Dependent <input type="checkbox"/> No
	2 If yes, please check one: <input checked="" type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Automobile/Medical
	3 If yes, also indicate name and policy number of insurance company. Name of Insured: <u>John Doe, Sr</u> Policy #/Group #: <u>#P123456789</u> I.D. #: <u>ABC12345678</u> Company: <u>USA Insurance Company</u>
	4 Have you filed a claim with the above company? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	5 Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above. EOBs attached indicating balances not paid
	6 Name and Address of Employer of: <input checked="" type="checkbox"/> Insured, if employed <u>USA Industries, 456 Main Street, Anywhere, CO 11111-2222</u> <input type="checkbox"/> Spouse, if insured is married _____

F-1. Date of accident or sickness <u>12/12/07</u>	Date of first treatment. <u>12/12/07</u>
2. Nature of sickness or injury. <u>Fall down stairs</u>	
3. If injury, describe how and when accident occurred and indicate if work related <u>Fell down icy steps when leaving my home for school in the morning on 12/12/07</u>	
*4. If injured in practice or play or sport, indicate which sport. <u>N/A</u>	Check One: <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other
5. Have you previously been troubled with this condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date _____	
6. Give name of all other physicians consulted <u>N/A</u>	
7. Hospitalized? If so, where and what dates Where? <u>N/A</u> From: _____ To: _____	
8. Health Center referral? <input type="checkbox"/> Yes If yes, attach referral to claims form. <input checked="" type="checkbox"/> No If no, please explain <u>Emergency, Health Center not open (or no Health Center referral required)</u>	

G 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 Receipts for out-of pocket expenses attached

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

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

Signature of College Official _____ **Title** _____ **Date** _____

I 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 of 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.

J Patient's or Authorized Representative's Signature John Doe, Jr. signature **Date** 12/18/07

If Authorized Representative, Relationship to Patient _____

STREET CITY STATE Zip + 4

INSTRUCTIONS FOR COMPLETING THIS CLAIM FORM
PLEASE CLEARLY PRINT ALL INFORMATION TO EXPEDITE PROCESSING
REMEMBER FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY DELAY PROCESSING OF CLAIMS

Examples are shown in red

- A.** Address for submitting completed form; a telephone number is included for any questions
- B.** "COVERAGE VERIFIED" box – **DO NOT WRITE IN THIS BOX**
- C.** Fraud Alert Notice
- D.** Portion to be completed in its entirety
1. Please indicate Name of School you attend
 2. Include the Policy Number (For Student Accident & Sickness plans this is located on the front of the Accident & Sickness brochure and may begin with AIH, AMH or SSH, followed by 7 digits; for Intercollegiate Sports plans, the athletic department can provide you with the policy # that will begin with All or CSI, followed by 7 digits)
 3. Indicate the Date of Birth for the Primary Insured
 4. Provide Last Name, First Name and Middle Initial
 5. Insert Social Security # (Student ID #) of the Primary Insured
 6. Include Telephone # where you can be reached with any questions
 7. Provide current address where EOBs (Explanation of Benefits), reimbursements, etc. can be mailed
 8. Include permanent home address for correspondence when not at School
 9. If the claim is for a dependent, please give complete name, the relationship to the Primary Insured and the Date of Birth of the dependent
- E.** This box is to be completed in its entirety if the Primary Insured is covered under any other insurance plan
1. Indicate if you are currently covered under another medical &/or hospital insurance plan as a primary insured or as a dependent
 2. If yes, please check the appropriate box for the type of coverage
 3. If yes, provide the name of the primary insured, the policy or group #, the individual ID # and the name of the insurance company
 4. Indicate if you have filed this claim with the above referenced insurance company
 5. Include with this form the Explanation of Benefits providing information on benefits paid &/or denied by the above referenced insurance company
 6. If employed, provide employer information for the primary insured and information for an employed spouse, if married
- F.** It is important to make certain to complete all the information in this section (items 1-8) regarding the details of the accident or sickness for which this claim form is being submitted
1. This should be the actual date of the accident or sickness; Indicate the date of first treatment
 2. Please provide the nature of the accident that caused the Injury or the specifics of the illness
 3. If you are filing a claim for an injury caused by an accident, please provide the details of the accident
 4. **MOST IMPORTANT** – If the injury is a result of an accident while practicing or playing in a sport, please indicate the sport and check one of the boxes to the right to show whether participation was in an Intramural, Intercollegiate or Other program: **ALL CLAIMS FOR PARTICIPATION IN A SCHOOL SPONSORED SPORT MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL**
 5. Indicate if this is a reoccurrence of a condition which previously troubled you and for which you sought medical advice; provide date
 6. Provide the names of physicians and providers previously consulted
 7. Information regarding any hospitalizations related to the condition for which this claim is being submitted
 8. Did you secure a Health Center referral before visiting a provider? Not all plans require a referral from the Health Center, however, make certain to confirm with the Health Center if a referral is required. Failure to do so may result in a decrease in benefits available or non-payment of benefits in their entirety. Read your brochure to check for referral requirements and the exceptions.
- G.** If you pay out-of-pocket for services rendered at the time of service, make certain to collect a receipt for payment made. Unless a paid receipt or statement from the provider indicates you remitted payment, payment will be made to the providers (hospital, physician, etc.)
- H.** Section for required authorized signature for athletic claims
- I.** Authorization to release to the "Company" any medical information required in order to process claims as related to this claim submission, as well as, certifying that the information provided on the claim form is true and correct
- J.** Signature of the patient for whom this claim form is being submitted or, if a dependent, the authorized representative. If a representative, please indicate relationship to the patient and the address of the representative.