



ACCIDENT CLAIM FORM

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS AND PRIMARY EOBs
3. COMPLETE FORM ONLINE OR
MAIL, FAX or EMAIL TO ACI
E-mail: claims@acitpa.com



Administrative Concepts, Inc.

PO Box 4000

Collegeville, PA 19426

Phone (888) 293-9229 Fax (888)293-9299

POLICY

NUMBER: _____

CLAIMANTS INFORMATION

- (1) Claimant's First name _____
- (2) Claimant's Last name: _____
- (3) Claimant's Date of Birth _____ (4) Gender ___M ___F
- (5) Home Address _____ (6) City _____
- (7) State ____ Zip Code _____
- (8) Claimant's Parent/ Guardian Contact Name _____ (9) Phone Number _____
- (10) Email Address _____
- (11) Date of Injury _____ (12) Time of Injury _____
- (13) Where did Injury occur? _____ (14) Date of first treatment _____
- (15) How did injury occur? _____
- (16) Part of body injured (what side, if applicable) _____ (17) Type of sport (if applicable) _____

Please attach any Additional Documentation

OTHER INSURANCE STATEMENT

Does the Claimant or Claimant's Parent or Guardian have medical/health care that the Claimant is enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage?
_____ Yes _____ No

If YES, Name of the Insurance Company _____

Policy # _____

Policyholder Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone # _____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

SIGN: Parent or Guardian: _____ Date _____

PAYMENT WILL BE MADE 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.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. 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 determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

The laws of some states require us to furnish you with the following notices:

WARNING Any person who knowingly

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, **or specific to AR and RI** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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:** and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (**or specific to LA, TX and W VA:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (**or specific to NM:** to civil fines and criminal penalties.)

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

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with 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 is guilty of insurance fraud.

Oklahoma: 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.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING

Colorado: 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine /Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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

POLICYHOLDER VERIFICATION SECTION

Claimant's Name _____

Date of Injury _____

At time of Injury was the claimant involved in a sponsored & supervised activity? ____ Yes ____ NO

If athletics, please designate the event name and sport _____

Additional Comments or Notes: _____

Name of Representative Completing this form _____

Signature _____ Title _____ Date _____

Please attach any Additional Documentation

Claim Filing Instructions

The parent completes the Claimant Information, Other Insurance Statement, and Affidavit section. The authorized official with Alaska Youth Soccer Association completes the Policyholder Verification section.

Once completed, send the form to ACI:

Mail: ACI, P.O. Box 4000, Collegeville, PA 19426-9000

Fax: 610-293-9299

Email: claims@acitpa.com

Helpful Information for Expediting Payment:

•**Complete Claim Information** – ACI suggests providers submit standardized billing statements (UB-04 for hospital charges, CMS-1500 for physician charges).

•**Payment to Medical Providers** – Claim payments are sent directly to the medical provider unless proof of payment is submitted with the medical bill.

•**Other Insurance** – If a primary insurance carrier paid a portion of the claim, include the Explanation of Benefits (EOBs) with your submission.

Questions? Contact ACI:

•Customer Service (Toll-Free): (888) 293-9229

•Customer Service (Local): (610) 293-9229

•Email: claims@acitpa.com

•Hours: 8am–5pm EST, Monday–Friday