Reset Form | Print

Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM TO:

NAHGA Claim Services
P.O. Box 189
Bridgton, ME 04009-0189
For questions call: 1-877-497-4980
Fax: 1-207-647-4569
Email: eiia@nahga.com

IMPORTANT NOTICE:
The student insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits (EOB), send it to us with corresponding itemized insurance bills.

If this form is not completed in FULL, this claim cannot be processed and will be returned. Please print legibly or the claim form will be returned.

## PART 1: STUDENT STATEMENT— MUST BE COMPLETED & SIGNED BY STUDENT

(1) School Name: (2) Policy Number:

(3) Student—Last Name, First Name: (4) Student ID#:

(5) Street Address (all insurance info / requests will be sent to this address):

(6) City, State, Zip (7) Phone Number & Email Address:

(8) Date of Birth: (9) ☐ Female ☐ Male (10) ☐ Single ☐ Married (11) ☐ Graduate ☐ Undergraduate (12) ☐ Domestic ☐ International

(13) This claim is for a(n) : ☐ Accident ☐ Sickness ☐ Other (14) Is this related to a sport? Y N If yes, name of sport _____

If Other, please specify: _____ Type of Sport: ☐ Intercollegiate ☐ Club ☐ Intramural Sport?

(15) Exact Date/Onset of Accident or Sickness: (16) First date of medical treatment: (include medical provider's name and phone number)

(17) If an Accident, describe how it occurred: _____ (18) Body Part Affected: _____ L R

(19) If Sickness, reason for seeking medical treatment: _____

(20) Have you previously been troubled by this condition/injury? Y N If yes, last date of treatment: _____

Prior treating physician (name and phone number): _____

(21) Were you seen and referred by Student Health Services? Y N If yes, when: _____ Authorized by: _____

*Student Health Services Official Signature*

## PART 2: PARENT OR GUARDIAN STATEMENT

If the student is under 26 years old and is insured, all the charges must be filed with the other insurance carrier first and copies of the Explanation of Benefits (EOBs) will be required for all charges submitted. If the student is not insured, a letter denoting lack of coverage or verification by telephone from the employer or insurance company is required. BLANKS ARE NOT ACCEPTABLE, INCOMPLETE CLAIM FORMS WILL BE RETURNED AND DELAY YOUR CLAIM!

(1) Head of Household: (2) Date of Birth: (3) Home Phone #: (4 )Employer Name and Phone Number:

(5) Insurance Co. Name and Phone Number: (6) Insurance Co. ID #:

(7) Is Student Insured? ☐ Yes ☐ No (8) Is this Insurance plan a government funded program (Medicaid, Military)? ☐ Yes ☐ No

To any medical care provider, medical care facility, Insurer, government-sponsored health plan or employer: I grant authorization *(while my claim is pending)* of the release of any medical information about me to NAHGA Claim Services and its representatives, EIIA, United States Fire Insurance Company and other persons or groups performing business or legal services relating to my claim. This applies to all information necessary to determine the eligibility of my claim. A copy of this authorization *(one of which will be given to me by NAHGA Claim Services upon my request)* will be valid as this one for a period of 24 months from the date of my signature. I may revoke this authorization by written request to NAHGA Claim Services.

*I certify that the above information provided by me in support of this claim is true and correct. I understand that if I knowingly misrepresent or falsify essential information requested by this form I may, upon conviction, be subject to fine or imprisonment.*

New York: 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.

Insured Student's Signature: _____ Date: _____

Participating Institution's Authorization: _____ Date: _____

*FOR PRIVACY POLICY INFORMATION PLEASE GO TO: www.fairmontspecialty.com*
*PAYMENT WILL BE MADE TO THE PROVIDER OF SERVICE UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION. CLAIM FILING PROCEDURES ARE ON THE BACK OF THIS DOCUMENT.*

## PART 3: MUST BE COMPLETED BY AN ATHLETIC DEPARTMENT OFFICIAL. PLEASE ATTACH ATHLETIC TRAINER NOTES.
## Please be advised that the Claims Administrator reserves the right to request additional information as needed.

How long has the athlete played for your Institution?: _____Year (s) Current Year: ☐ Freshman ☐ Junior

First year transfer student? ☐ Y ☐ N ☐ Sophomore ☐ Senior

Athlete reported an: ☐ Accident ☐ Overuse Injury Date of Accident or Injury: _____ Date athlete reported Accident or onset of symptoms_____

Sport where the injury occurred: _____ Supervised by: _____

This occurred during a: ☐ Game ☐ Scheduled & Supervised Practice (required of the entire team) ☐ Supervised NCAA/NAIA approved Weight Training & Conditioning Session

Body part injured: ☐ L ☐ R Explain mechanism or onset of injury:

Was immediate care required? ☐ Y ☐ N Type of care rendered:

Has the student ever injured the above body part in the past? ☐ Y ☐ N If yes, when was the last date of treatment: _____

Was the athlete examined and cleared for full activity with no restrictions by the attending physician? ☐ Y ☐ N If yes, attach a copy.

*I certify that the above information provided by me in support of this claim is true and correct and that records are on file with the Institution's Athletic Department to document the above facts. I understand that if I knowingly misrepresent or falsify essential information requested by this form, I may be subject to conviction.*

_____ _____

*Athletic Trainer / Athletic Department Official's Signature* *Date*

IMPORTANT NOTICE!

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Florida Claimants: WARNING: 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.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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

Notice to Oklahoma Claimants: Any person who knowingly, 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.

Notice to Pennsylvania Claimants: 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.

Notice to Tennessee and Virginia Claimants: 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.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime may be subject to fines and confinement in state prison.

CLAIM FILING PROCEDURES:

1. An Accident must be reported to the Student Insurance Coordinator within 24 hours following the Accident. Accidents incurred during supervised practice or play should be reported to the Athletic Trainer or Athletic Department Official immediately following the injury.

2. If you are insured by an HMO, PPO or similar arrangement, they must be contacted for proper instruction or authorization on covered health care. HMO & PPO Plans must be utilized. If you do not use the facilities or services of the HMO, PPO or similar arrangement, medical benefits may be reduced.

3. The coverage afforded by the Student Plan may provide benefits in *EXCESS* of any other coverage the student may have. If so, all eligible charges submitted must be accompanied by an Explanation of Benefits (EOB) from the primary insurance carrier(s). The Insurance Section in Part 1 of this Claim Form must include insurance information for BOTH parents if the student is 26 years of age or under. Blank lines or N/A are not acceptable.

4. Incomplete Claim Forms will result in a processing delay. Allow up to 4 weeks for processing after all information is received.

5. Please ensure that all bills are itemized insurance bills, listing the patient's name, date of service, diagnostic code, service code and the provider's tax identification number. (HCFA and UB forms are preferable.)

6. File only one Claim Form per loss (Accident or Sickness). Once the initial Claim Form has been filed, additional information submitted should be identified with the school's name, the student's name, ID# and the initial date of loss.

IMPORTANT INFORMATION:

- Initial medical treatment must take place within *90* days from the date of Accident or Sickness.
- Written notice of a claim must be given within ***180*** days after a covered loss occurs.
- All eligible expenses must be submitted within one year from the date of service.

If you have any questions about filing your claims, please contact your school's Student Insurance Coordinator or NAHGA Claim Services at 1-877-497-4980.

PLEASE KEEP A COPY OF THIS CLAIM FORM AND ALL INFORMATION SUBMITTED FOR YOUR RECORDS!