



ACE American Insurance Company

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

MAIL TO:
 Administrative Concepts, Inc.
 994 Old Eagle School Road
 Suite 1005
 Wayne, PA 19087-1802
 www.visit-aci.com

CLAIM FORM MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS.

EDI PAYOR ID# 22384

ISM International Plan

**- PLEASE PRINT ALL INFORMATION -
 MUST BE COMPLETED AND SIGNED BY STUDENT**

Name and Address of School			Policy Number GLMN00174646	Birth Date
Insured Student's Name			STUDENT ID #	PHONE #
LAST NAME	FIRST NAME	M.I.		
Present Address		CITY OR TOWN	STATE	ZIP # + 4
NO. AND STREET				
Home Address		CITY OR TOWN	STATE	ZIP # + 4
NO. AND STREET				

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Describe nature of injury and how it occurred _____

Date and hour of occurrence _____

Was the injury due to practice or play of a sport? Yes No

Which sport? _____

Intercollegiate Interscholastic Intramural Club

Is condition work related? Yes No

Is condition due to auto accident Yes No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition? Yes No

Seen by: _____ Date: _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of sickness _____

Date symptoms first noticed _____

If pregnancy, date of last menstrual period _____

What is the exact nature of the sickness? _____

Have you ever had the same or similar condition? Yes No

If yes, date of first treatment _____

Date of last treatment _____

Were you treated in the Health Service for this condition? Yes No

Seen by: _____ Date: _____

PLEASE PRINT, SIGN AND MAIL THIS FORM TO ADMINISTRATIVE CONCEPTS, INC.

Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

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 _____

or Legal Designation _____
 STREET CITY STATE ZIP CODE + 4

FRAUD NOTICE

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

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

California , Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or specific to LA and TX: 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.)

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.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing 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 fact material 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.

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.

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.

District of Columbia, 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, (or specific to DC: 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.

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

Maine: 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: A 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.

Procedures for Submitting a Claim Form for ACE American Insurance Company's International Student Accident & Health Insurance (ISAH)

Should an accident or illness occur requiring that a claim be submitted, please follow these instructions to ensure speedy and accurate payment.

- This coverage is underwritten by ACE American Insurance Company. Policies are issued and claims are paid by Administrative Concepts, Inc. (ACI). Refer to your ID Card for information on your policy. You can reprint a copy of your ID Card from ACI's Web site (www.visit-aci.com). In order to utilize ACI's Web site, you must be registered.
- *Claim Forms:* You can obtain a Claim Form from your school's health office or online (<https://secure.visit-aci.com/enrollment/home/ism.htm>). All claims must be submitted on the proper form. Complete in full, sign, and return the Claim Form, along with all itemized bills, to the below address within 30 days of the visit. **If the claim is for an accident, explain what happened and identify the injured area of the body. Please do not omit any information when filling out the Claim Form – failure to complete the form in its entirety may result in payment being delay.**

Administrative Concepts, Inc. (ACI)
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
Phone: 610-293-9229

- Contact all physicians, hospitals, and other healthcare providers who have treated or will be treating you, and give them the information about your insurance. You can ask the providers to bill ACI directly at the above address. If the providers will not bill the insurance for you, request copies of all the bills; include the **name of the provider, date of service, the charges, the diagnosis codes, procedure codes, and the provider's Federal Income Tax ID Number**. **ACI cannot process claim payments from balance due statements or collection notices.**
- Be sure to attach a copy of any bills you may have to the Claim Form. Future bills can be submitted to ACI on their own. **Providers may submit bills electronically using Payor # 22384.** (Please make sure your name and ID Number are clear on all paperwork.)
- If you have paid any providers directly, be sure to attach a receipt of payment to the itemized bill. Please let ACI know whom to reimburse (to whom the check should be made payable, and where reimbursement should be sent).
- Make copies of all forms for your records.
- You will receive a response from ACI within 2 weeks.
- You can check the status of your claim on ACI's Web site – or call ACI's claim department at 610-293-9229/1-888-293-9229.

Contact Anna M. Ferguson at ISM to request more claim forms
(302-656-4944 ext. 126 or anna@isminc.com)

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