ACCIDENT CLAIM FORM

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

BOTH SIDES OF CLAIM FORM MUST BE COMPLETED AND RETURNED WITH ITEMIZED BILLS WITHIN 30 DAYS.

EDI PAYOR ID# 22384

Any person who knowingly presents a false or fraudulent claim for payment of 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.

PART A: SCHOOL AND PARENT

Policy No. _____

(1) School: _____ (2) School ID#: _____
(3) School Address: _____ (4) School Phone #_____
(5) Student: _____ (6) Student's Social Security# _____
(LAST NAME) (FIRST NAME)
Male ❑
(7) Grade:_____ (8) Birthdate_____ (9) Female ❑ (10) Date of Injury_____ (11) Time_____
(12) Where did injury occur?_____ (13) Date of first treatment_____
(14) How did injury occur?_____
(15) Part of body injured_____ (16) Type of sport_____
(17) At the time of injury was the student involved in a school sponsored & supervised activity? ❑ Yes ❑ No
(18) If athletics, designate: ❑ P.E. Class ❑ Intramural ❑ Interscholastic ❑ Practice ❑ Game
(19) Under whose supervision?_____ Was he/she a witness? ❑ Yes ❑ No
(20) Signature: X_____ Title_____ Date_____
(must be signed by school official unless injury did not occur during school activity.)

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.

PART B: PARENT OR GUARDIAN STATEMENT

(1) Student's Social Security #_____ (2) Date of first treatment_____
(3) Father's Name_____ Social Security #_____
(4) Mother's Name_____ Social Security #_____
(5) Home Address_____
(STREET) (CITY) (STATE) (ZIP) (HOME PHONE NO.)
(6) Father's Employer_____ Business Phone #_____
(7) Employer's Address_____
(8) Name and Address of other Insurance Company_____
(9) Policy No._____ ❑ Group ❑ Individual ❑ Other ❑ No Other Insurance
(10) Mother's Employer_____ Business Phone #_____
(11) Employer's Address_____
(12) Name and Address of other Insurance Company_____
(13) Policy No._____ ❑ Group ❑ Individual ❑ Other ❑ No Other Insurance

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_____

or Legal Designation _____
STREET CITY STATE ZIP CODE + 4

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

INSTRUCTIONS

1. PART A - must be completed by the school.
2. PART B - must be completed by Parent or Guardian.
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the insurance company separately. Please show name of school on all later bills.
4. Mail this report and bills within 30 days after the first treatment to:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** 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.

- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.

- ***For residents of 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.

- ***For residents of the District of Columbia:*** *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.

- ***For residents of Florida:*** 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.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- ***For residents of Maine, Tennessee, Virginia and 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 include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** 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 CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of 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.

- ***For residents of Ohio:*** Any person who, 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.

- ***For residents of Oklahoma:*** WARNING: 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.

- ***For residents of Pennsylvania:*** 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.

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