



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.

-PLEASE PRINT ALL INFORMATION-

PARTS I & II MUST BE COMPLETED AND SIGNED BY STUDENT

Name of Group, City and State _____		Graduate <input type="checkbox"/> Domestic <input type="checkbox"/>	Policy Number _____	Birth Date _____
		Undergraduate <input type="checkbox"/> International <input type="checkbox"/>		
Insured Member's Name _____				
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEMBER ID#	PHONE #
Present Address _____				
NO. AND STREET	CITY OR TOWN	STATE	ZIP CODE + 4	
Home Address _____				
NO. AND STREET	CITY OR TOWN	STATE	ZIP CODE + 4	NAME OF HOME COUNTRY
If claim for dependent, give dependent's name _____ relationship to Insured _____ Age _____				

COMPLETE THIS SECTION FOR ACCIDENT CLAIM	COMPLETE THIS SECTION FOR SICKNESS CLAIM
Nature of Injury (Describe fully, including which part of body was injured.) _____	Date of Sickness _____
Describe How, When and Where Accident Occurred (Include Date and Time) _____	Date symptoms first noticed _____
Was the injury due to practice or play of a sport? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the exact nature of the sickness _____
Which Sport? <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Intramural <input type="checkbox"/> Club <input type="checkbox"/> Other	If pregnancy, date of last menstrual period _____
Is condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is condition due to auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of first treatment _____
If yes, please attach detailed policy information on all motor vehicles involved in accident.	Date of last treatment _____
Were you treated in the Health Service for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you treated in the Health Service for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Seen by: _____ Date: _____	Seen by: _____ Date: _____
If your claim is for services outside of the Health Service, were you referred? <input type="checkbox"/> Yes <input type="checkbox"/> No	If your claim is for services outside of the Health Service, were you referred? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, why? Away from school	If not, why? Away from school
For what reason: _____	For what reason: _____

**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 THE 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

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months? Yes No

If yes, indicate the name and address of the company _____

Effective date of coverage: _____ Expiration date: _____ Policy No. _____

Have you filed a claim with any other insurance company? Yes No

I hereby certify that the above information given by me in support of this claim is true and correct.

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

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

The following section is applicable if you are covered under any other medical insurance plan.

Mother's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Father's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Spouse's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Arkansas	Kansas	North Carolina	South Dakota
California	Louisiana	North Dakota	Texas
Connecticut	Massachusetts	Nebraska	Utah
Georgia	Michigan	Nevada	Vermont
Iowa	Missouri	Puerto Rico	Wisconsin
Illinois	Mississippi	Rhode Island	West Virginia
	Montana	South Carolina	Wyoming

; YbYfJW: fU X'K Ub]b['ftc' VY'i gYX'Z:f' Uwcj YgUHY'g'cb' nL Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

5'UVUa U - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

5'Ug UZ8 YUk UFYZ>XU cZbX]UbUzC 'U ca U - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

7 c'cfUXcZK Ug\]b[tcb'8 '7'Z< Uk U]ZA U]bYZHYbbYggYYZJ]f[]b]U- 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 coverage.

5 f]ncbUEA]bbYgcHLEBYk >YfgYnzBYk 'A YI]Wt - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

? YbH W,nZC\]cZCfY[cb - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

: 'cf]XU! Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

A UfmUbX - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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.

BYk 'c'Ua dg\]fY- 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.

DYbbgmj Ub]U - Any person who knowingly and with intent to defraud any insurance company or other person files 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.

F\ cXY'g'UbX - 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.

K Ug\]b[tcb'GHUHY - 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.