Excess Accident Medical Expense

HOW TO FILE A CLAIM

1. **Complete all items on the attached claim form.**

2. **Attach the following documents:**

   - **Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.**
   - **Copies of the Explanation of Benefits from your primary insurance carrier**

3. **Send the completed and signed claim form and all required documents to:**

Administrative Concepts, Inc
P.O. Box 4000
Collegeville, PA 19426-9000
Fax: 610-293-9299
Phone: 888-293-9229
Email: aciclaims@acitpa.com

4. **Retain a copy for your records.**

This insurance plan is excess insurance and is designed to provide maximum benefits at minimum cost and is secondary to all other insurance you may have. Please submit all expenses to your primary insurance first. Once that claim has been processed, please include their Explanation of Benefits when submitting your claim for benefits under this policy.

Attention Medicare and Medicaid Enrollees: This insurance is primary to your Medicare or Medicaid coverage. If you wish payment to be made to you, you must provide proof of payment from the provider.

YOU WILL BE CONTACTED BY ADMINISTRATIVE CONCEPTS, INC IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE CALL ADMINISTRATIVE CONCEPTS, INC AT 888-293-9229

Accident Medical Expense

Insured's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Soc. Sec. No.** _____

Member ID (if appl.)_____

Insured's Address_____ **Phone No. (H)**_____

_____**Phone No. (W)**_____

Email address: _____ **Phone No. (C)** _____

Policy Number (Required)_____ **Insured's Date of Birth** _____/_____/_____

Are you eligible for or enrolled in Medicare? _____ **Are you enrolled in Medicaid?** _____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____
_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	State	Zip	Phone

_____

_____

If hospitalized, please provide name and address of hospital(s) where treatment was received:

_____

Do you have any other insurance that may provide coverage for this accident or loss? _____ **If yes, please identify name, address, and policy number of all other insurance:** _____

_____

If you do not have any other insurance that would cover this loss please complete the "Certification of No Other Insurance" portion of this form.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize any insurance company, physician, hospital or other healthcare provider, or any other person who may have knowledge regarding this claim to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Insurance Company, Administrative Concepts, Inc or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signed (Insured or authorized person) _____ **Date** ____/____/____

I authorize payment of medical benefits directly to the provider(s) for services rendered in connection with this claim.

Signed (Insured or authorized person)_____ **Date** ____/_____/___

CERTIFICATION OF NO OTHER INSURANCE

I, _____**hereby certify that I have no other accident, health, Medicare, Medicaid or any other insurance covering this loss.**

Signed (Insured or authorized person) _____ **Dated** _____/_____/_____

Important Notice

- ***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 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.
- ***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.