Instructions for Accident Claim Form

Claim form MUST be signed and dated.

Section I – POLICYHOLDER'S INFORMATION

- Submit a completed claim form via either mail or by facsimile.

Section II – Explanation of Benefits (EOB)

- Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).
- If the claim is for a car accident, please include the police report and the car insurance company's corresponding Explanation of Benefits (EOBs).

How to file a Medical Claim

Attached is a claim form for your accident policy. Please forward claims and questions to the following address:

Administrative Concepts, Inc.
PO Box 4000
Collegeville, PA 19426

Phone: 888-293-9229

Fax: 610-293-9299

Email: aciclaims@acitpa.com
www.acitpa.com

General Accident Claim Form

CLAIM FILING PROCEDURE

Proof of Loss must be submitted within 90 days of the accident, additional bills must be submitted within 90 days of the date of treatment. Incomplete claim forms will result in a processing delay.

Please complete the Checklist:

- ☐ Completed Claim Form with Signatures
- ☐ Medical Bills Attached
- ☐ Medical Records Attached
- ☐ Photo of Injury (if applicable)
- ☐ Explanation of Benefits from other insurance carrier (if applicable)
- ☐ Other (if applicable): _____

Section I - Policyholder Information			
Policyholder Name	Certificate/Policy Number	Group Number	
Phone Number	Email		
Address	City	State	Zip Code

Section II – Patient Information			
Patient Name (if different than Policyholder)	Patient Date of Birth	Patient SSN	
Other Insurance	Does the patient have any other Medical or Supplemental insurance? Select all that apply: ☐ Medical ☐ Supplemental ☐ Worker's Compensation ☐ Auto ☐ Medicare ☐ Medicaid ☐ Any other State program ☐ Homeowners		

Section III – Injury Information			
Report Date/ Date of Injury/Death	Occupation Related? ☐ Yes ☐ No	Has this been filed with Worker's Compensation? ☐ Yes ☐ No	
Location Where Accident/Death Occurred	City	State	Zip Code
Nature of Injury/Cause of Death			
Description of Incident			
Describe all Injuries with Diagnosis Codes (if Available). *Please provide proof of diagnosis from medical billing or signed Physician's Statement.*			
Dates of Service/Treatment	Type of Treatment		
Was there Hospital Confinement? *If yes, please submit itemized hospital bill including room and board charges.*	Was there Ambulance Transport? *If yes, please submit ambulance bill.*		
Attending/Treating Physician/Facility	Primary Physician/Facility		
	Mailing Address		
	City	State	Zip
	Phone Number	Fax Number	

Signature of Injured Party _____ **Print Name** _____

Signature of Beneficiary/Dependent _____ **Print Name** _____

Address of Beneficiary/Dependent _____ **Phone Number** _____ **Date** _____

HIPAA AUTHORIZATION

I HEREBY AUTHORIZE ANY DENTIST, PHYSICIAN, INSURANCE COMPANY, ORGANIZATION OR PLAN SPONSOR TO RELEASE ANY INFORMATION INCLUDING FULL COPIES OF THEIR RECORDS TO THE PAN-AMERICAN LIFE INSURANCE COMPANY, ITS ADMINISTRATION FOR ANY MEDICAL TREATMENT, SERVICES OR BENEFITS RENDERED OR PAYABLE TO ME ON MY BEHALF. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. **I HEREBY CERTIFY THAT THE FOREGOING ANSWERS ARE TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE. WHOEVER IN ANY DOCUMENT REQUIRED BY THE TITLE OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 MAKES ANY FALSE STATEMENT OR REPRESENTATION OF FACT SHALL BE FINED NOT MORE THAN $10,000, OR IMPRISONED NOT MORE THAN FIVE YEARS OR BOTH.**

Signature (claimant or authorized person)

Date

Print Name

FRAUD WARNING

For your protection, the laws of several states, including Alaska, Connecticut, District of Columbia, Delaware, Georgia, Indiana, Illinois, Idaho, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, North Carolina, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Wyoming, Wisconsin, and others require the following or substantially similar warning statement to appear on this form.

FRAUD WARNING

"Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, submits an application and/or files a statement of claim containing any false, incomplete, misleading information is guilty of insurance fraud which is a felony."

FRAUD WARNING FOR ALABAMA AND ARKANSAS RESIDENTS

"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."

FRAUD WARNING FOR ALASKA, MINNESOTA RESIDENTS

"A person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be prosecuted under state law"

FRAUD WARNING FOR ARIZONA, NEW JERSEY RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

FRAUD WARNING FOR TEXAS & CALIFORNIA and TEXAS RESIDENTS

For your protection California Law requires the following to appear in this form (for California only): "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."

FRAUD WARNING FOR COLORADO RESIDENTS

"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."

FRAUD WARNING FOR DISTRICT OF COLUMBIA, TENNESSE, VIRGINIA AND WASHINGTON RESIDENTS

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."

FRAUD WARNING FOR FLORIDA, DELAWARE, IDAHO, INDIANA, OKLAHOMA RESIDENTS

"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."

FRAUD WARNING FOR KENTUCKY, MASSACHUSETTS, NEBRASKA AND PENSYLVANIA RESIDENTS

"Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties."

FRAUD WARNING FOR LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS

"Any person who knowingly or willfully 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 confinement in prison."

FRAUD WARNING FOR OHIO RESIDENTS

"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."

FRAUD WARNING FOR PUERTO RICO RESIDENTS

"Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years."