



NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for **accident medical claims**.



Policies With Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Deductible (\$200)

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Claim Form

This company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is sent.

- If the injured person has primary health insurance has the claim been submitted first to the primary?* _____
- If claim has first been submitted to the primary, are copies of the EOB's (explanation of benefits attached)?* _____
- Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* _____
- Is part (B) of the claim form completed by the injured person and signed?* _____
- Are the attached medical bills itemized in either a HCFA1500 or UB92 form?* _____
- Is part (B) , item number 3, (social security number) completed?* _____

Mailing the Claim

When completed in full, mail the attached completed form, itemized medical bills and copies of the EOB's (explanation of benefits, for use if coverage is excess) to:

The Loomis Company
AYSO Accident Claims
P O Box 13906
Reading, PA 19612-4085

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (888) 585-7065 or (800) 782-0392.

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanation of benefits are available for reimbursement.

ACCIDENT DEDUCTIBLE CREDIT SHEET

Injured's Name: _____

Policyholder's Name: _____

Date of Injury: _____

Name & Address check should be sent to:

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

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