
NOTIFICATION OF INJURY

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

Excess Coverage

If your accident policy is **Excess**, the policy is secondary to an injured party primary health insurance. **Excess** policies will not cover primary insurance deductibles, co-pays, program limits, out of network care, or workers compensation related injuries. If injured party does not have primary care, excess coverage becomes primary. Either way, a deductible applies for any accident claim.

Deductible

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 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 CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 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 to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company? _____

If claim has first been submitted to the primary health insurance company, are copies of 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 CMS 1500 or UB04 form? _____

Is part (B), item number 3 (social security number) completed? _____

Mailing The Claim

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

The Camp Team
7615 W. 38th Ave., Suite B 109
Wheat Ridge, CO 80033
303-422-1276 (Fax)

Third Party Administrator

After the initial claim submission to The Camp Team, the claim will be processed by our office and submitted to **Loomis Benefits** in Reading, PA, where a claims adjuster will begin processing the claim.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim forms at the time the itemized bills and explanations 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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NOTICE

WARNING: 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 may be a crime.

PART A – This PART MUST be completed, dated and signed by an official or the Organization.			
1. Name of Organization (Policyholder)			
2. Policy No.			
3. Name of Organization or Team (if different from Policyholder)			
4. Address of Organization		(Street)	(City)
		(State)	(Zip)
5. Name of Injured Person (Insured)		(First)	(Middle)
			(Last)
6. Date of Accident/Injury		7. Injury Occurred:	
Mo	Day	Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/>	
/	/	Other _____	
		8. Type of Sport or Activity:	
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		12. Name of Supervisor of Activity	
		13. Was he/she a witness to Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Signature of Organization Official		15. Title of Official	
X _____			
		16. Area Code/Telephone No. ()	
		17. Date Signed	

PART B – This PART MUST be **completed, dated** and **signed** by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM Check one: Injured Person Parent Guardian

Give the following information about the Injured Person:

1. Date of Birth Mo Day Year / /	2. Male <input type="checkbox"/> Female <input type="checkbox"/>	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ()
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5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
()

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes No
If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)
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8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

Name of Mother or Female Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

9. If the Injured Person is married, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medial records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to American Sentinel Insurance Company, Aegis Security Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that I or my authorized representative will receive a copy of this authorization upon request.

X _____ _____ Check one: Injured Person Date: _____
 Signature (in writing) of Responsible Party Print Name Parent Guardian