

Please print or type. Incomplete forms will be returned.
 SEND COMPLETED FORM TO:



educational & institutional insurance administrators, inc.

NAHGA Claim Services
 P.O. Box 189
 Bridgton, ME 04009-0189
 For questions call: 1-800-952-4320
 Fax: 1-207-647-4569
 Email: eia@nahga.com

IMPORTANT NOTICE:
 The student insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits (EOB), send it to us with corresponding itemized insurance bills.

If this form is not completed in FULL, this claim cannot be processed and will be returned. Please print legibly or the claim form will be returned.

PART 1: STUDENT STATEMENT— MUST BE COMPLETED & SIGNED BY STUDENT

(1) School Name:		(2) Policy Number:	
(3) Student—Last Name, First Name:		(4) Student ID#	
(5) Mailing Address where insurance info/requests should be mailed		(6) City, State, Zip	(7) Phone Number
(8) Date of Birth	(9) <input type="checkbox"/> Female <input type="checkbox"/> Male	(10) <input type="checkbox"/> Single <input type="checkbox"/> Married	(11) <input type="checkbox"/> Graduate <input type="checkbox"/> Undergraduate
		(12) <input type="checkbox"/> Domestic <input type="checkbox"/> International	If claim is for a dependent, give dependents full name:
(13) This claim is for a(n): <input type="checkbox"/> Accident <input type="checkbox"/> Sickness		(14) Is this related to an Intercollegiate sport? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, what sport _____	
(15) Exact Date/Onset of Accident or Sickness:		(16) First date of medical treatment: (include medical provider's name and phone number)	
(17) If an Accident, describe how it occurred:		(18) Body Part Affected: _____	<input type="checkbox"/> L <input type="checkbox"/> R
(19) If Sickness, Reason for seeking medical treatment:			
(20) Have you previously been troubled by this condition/injury?		If yes, when: ____/____/20____	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Prior treating physician (name & phone number)	
(21) Were you seen and referred by Student Health Services?		If yes, when: ____/____/20____	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Authorized by: _____ <i>Student Health Services Official Signature</i>	

PART 2: PARENT OR GUARDIAN STATEMENT

If the student is insured, all charges must be filed with the other insurance carrier first and copies of the Explanation of Benefits (EOBs) will be required for all charges submitted. If the student is not insured, a letter denoting lack of coverage or verification by telephone from the employer or insurance company is required. **BLANKS ARE NOT ACCEPTABLE, INCOMPLETE CLAIM FORMS WILL BE RETURNED AND DELAY YOUR CLAIM!**

(1) Head of Household	(2) Date of Birth	(3) Home Phone #	(4) Other Parent/Spouse:	(5) Date of Birth	(6) Home Phone #
(7) Employer Name and Phone Number			(8) Employer Name and Phone Number		
(9) Insurance Co. Name and Phone Number			(10) Insurance Co. Name and Phone Number		
(11) Insurance Co. ID#:			(12) Insurance Co. ID#:		
(13) Is Student Insured? Yes <input type="checkbox"/> No <input type="checkbox"/>			(13) Is Student Insured? Yes <input type="checkbox"/> No <input type="checkbox"/>		

To any medical care provider, medical care facility, Insurer, government-sponsored health plan or employer: I grant authorization (*while my claim is pending*) of the release of any medical information about me to NAHGA Claim Services and its representatives, EIIA, Fairmont Specialty and other persons or groups performing business or legal services relating to my claim. This applies to all information necessary to determine the eligibility of my claim. A copy of this authorization (*one of which will be given to me by NAHGA Claim Services upon my request*) will be valid as this one for a period of 24 months from the date of my signature. I may revoke this authorization by written request to NAHGA Claim Services.

I certify that the above information provided by me in support of this claim is true and correct. I understand that if I knowingly misrepresent or falsify essential information requested by this form I may, upon conviction, be subject to fine or imprisonment.

Insured Student's Signature: _____ Date: _____
 Participating Institution's Authorization: _____ Date: _____

FOR PRIVACY POLICY INFORMATION PLEASE GO TO: www.fairmontspecialty.com

PAYMENT WILL BE MADE TO THE PROVIDER OF SERVICE UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION.
 INITIAL MEDICAL TREATMENT MUST TAKE PLACE WITHIN 90 DAYS FROM THE DATE OF ACCIDENT OR ONSET OF ILLNESS.

PART 3: MUST BE COMPLETED BY THE ATHLETIC DEPARTMENT OFFICIAL. PLEASE ATTACH ATHLETIC TRAINER NOTES.

How long has the athlete played for your Institution?: _____ Year (s) Current Year: Freshman Junior
 Sophomore Senior

Athlete reported an: Accident Date of Accident or Injury: ____/____/20____
 Overuse Injury Date athlete reported Accident or onset of symptoms: ____/____/20____

Sport where injury occurred: _____ Intercollegiate Intramural Club
Practice/Game Supervised by: _____ Scheduled Practice Scheduled Game

Body Part Injured: _____ L R
Explain mechanism or onset of injury:

Was immediate care required? Yes No Type of care rendered:

Has the student ever injured the above body part in the past? Yes No If yes, when was the last date of treatment: ____/____/20____

If yes, was the athlete examined and released for full activity by an orthopedic physician? Yes No

I certify that the above information provided by me in support of this claim is true and correct and that records are on file with the Institution's Athletic Department to document the above facts. I understand that if I knowingly misrepresent or falsify essential information requested by this form, I may be subject to conviction.

Athletic Trainer / Athletic Department Official's Signature Date

ATHLETIC TRAINER: PLEASE BE ADVISED THAT THE CLAIMS ADMINISTRATOR RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS NEEDED.

IMPORTANT NOTICE!

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Kentucky Claimants: 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 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.

Notice to Oklahoma Claimants: 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.

Notice to Pennsylvania Claimants: 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.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime may be subject to fines and confinement in state prison.

CLAIM FILING PROCEDURES:

1. An Accident must be reported to the Student Insurance Coordinator within 24 hours following the Accident. Accidents incurred during supervised practice or play should be reported to the Athletic Trainer or Athletic Department Official immediately following the injury.
2. If the student is insured by an HMO, PPO or similar arrangement, they should be contacted for proper instruction or authorization on covered health care. HMO & PPO Plans must be utilized. If you do not use the facilities or services of the HMO, PPO or similar arrangement, medical benefits may be reduced by 50%.
3. The coverage afforded by the Student Accident & Sickness Plan may provide benefits in **EXCESS** of any other coverage the student may have. If so, all eligible charges submitted must be accompanied by an Explanation of Benefits (EOB) from the primary insurance carrier(s). The Insurance Section in Part 1 of this Claim Form must include insurance information for BOTH parents if the student is under 23 years of age or a spouse if they are married. Blank lines or N/A are not acceptable.
4. Incomplete Claim Forms will result in a processing delay. Allow up to 4 weeks for processing after all information is received.
5. Please ensure that all bills are itemized, listing the patient's name, date of service, diagnostic code, service code and the provider's tax identification number. (HCFA 1500 and UB92 forms are preferable)
6. File only one Claim Form per loss (Accident or Sickness). Once the initial Claim Form has been filed, additional information submitted should be identified with the school's name, the student's name, ID# and the initial date of loss.

If you have any questions about filing your claim, please contact your Institution's Student Insurance Coordinator or NAHGA Claim Services at 1(800) 952-4320.

IMPORTANT INFORMATION:

- ◆ Initial medical treatment must take place within **90** days from the date of Accident or Sickness.
- ◆ Written notice of a claim must be given within **90** days after a covered loss occurs or begins or as soon as reasonably possible.
- ◆ The Insured Student must be under the care of a Doctor when the eligible Expenses are incurred.