STUDENT ACCIDENT CLAIM FORM

Mail to:
Administrative Concepts, Inc.
997 Old Eagle School Road, Suite 215
Wayne, PA 19087-1706
www.visit-aci.com

Claim Questions:
Glatfelter Public Practice, Program Administrator
52 Corporate Circle, Suite 210, Albany, NY 12203
Jennifer Ossenfort, 800-833-8822 Ext. 109
jossenfort@glatfelters.com

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 the following states, please see the reverse side: California, Colorado, District of Columbia, Florida, Maine, Maryland, Nevada, New Hampshire, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.

PART A: SCHOOL AND PARENT

Policy No.: _____

(1) Policyholder/School Name: _____

(2) School Address: _____ (3) School Phone #: _____

(4) Student:: _____ (5) Student's Social Security #: _____

(LAST NAME) (FIRST NAME)

(6) Grade: _____ (7) Birth date _____ (8) Male ☐ Female ☐ (9) Date of Injury: _____ (10) Time: _____

(11) Where did injury occur? _____ (12) Date of first treatment: _____

(13) How did injury occur? _____

(14) Part of body injured? _____ (15) Type of sport: _____

(16) At the time of injury was the student involved in a school sponsored & supervised activity? ☐ Yes ☐ No

(17) If athletics, designate: ☐ P.E. Class ☐ Intramural ☐ Interscholastic ☐ Practice ☐ Game

(18) Under whose supervision? _____ Was he/she a witness? ☐ Yes ☐ No

(19) Signature: X _____ Title: _____ Date: _____

(must be signed by school official unless injury did not occur during school activity.)

Administrative Concepts, Inc. does not share private health information except as required or permitted by law.
We are committed to guarding the private information entrusted to us.

PART B: PARENT OR GUARDIAN STATEMENT

(1) Student's Social Security #: _____ (2) Date of first treatment _____

(3) Father's Name: _____ Social Security #: _____

(4) Mother's Name: _____ Social Security #: _____

(5) Home Address: _____

(STREET) (CITY) (STATE) (ZIP) (HOME PHONE NO.)

(6) Father's Employer: _____ Business Phone #: _____

(7) Employer's Address: _____

(8) Name and Address of other Insurance Company: _____

(9) Policy No.: _____ ☐ Group ☐ Individual ☐ Other ☐ No other insurance

(10) Mother's Employer: _____ Business Phone#: _____

(11) Employer's Address: _____

(12) Name and Address of other Insurance Company: _____

(13) Policy No.: _____ ☐ Group ☐ Individual ☐ Other ☐ No other insurance

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

SIGN: Parent or Guardian: _____ Date: _____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature: _____ Date: _____

If Authorized Representative, Relationship to Patient _____

Or Legal Designation: _____

STREET CITY STATE ZIP CODE +4

ITEMIZED BILLS and EXPLANATION OF BENEFITS FOR MEDICAL EXPENSES MUST BE ATTACHED

INSTRUCTIONS

1. PART A - must be completed by the school.
2. PART B - must be completed by Parent or Guardian.
3. Attach all itemized medical/dental bills you have received to date. Later bills, receipts and explanation of benefits can be mailed to the insurance company separately. Please show student name and school name on all later bills. *Please note a "balance due" statement does not generally provide enough information for processing. Please request an itemized bill or a UB92 billing form from your service provider.*
4. Mail this form along with any itemized bills, explanation of benefits and paid receipts to Administrative Concepts, Inc.

Administrative Concepts, Inc., 997 Old Eagle School Road, Suite 215, Wayne, PA 19087-1706

IMPORTANT CLAIM NOTICE

California Residents: 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.

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.

District of Columbia Residents: 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.

Florida 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.

Maine/Tennessee Residents: 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.

Maryland/Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Nevada Residents: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

New Hampshire Residents: 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 R.S.A.638.20.

New York Residents: 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 $5000 and the stated value of the claim for each such violation.

Pennsylvania Residents: 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.

Texas Residents: 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.

Virginia Residents: 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.