Chesterfield Quarterback League
Accident Medical Insurance
How to File a Claim

Part 1 - To be completed by Coach or Team Member and signed. Make sure parent fills in birthdate and social security number if this information is not known.

Give form to parent and let them send bills and the claim form directly after completing your portion!

Part 2 - To be completed by Parent (if Claimant is a Minor). Two signatures are required - one under Affidavit and one under Authorization. Make sure other insurance information including identification number is provided. Submit fully completed claim form, itemized bills and explanation of benefits from the primary insurance company directly to the Claims Administrator. If they need additional information, they will be in contact with you. If you have any questions or if we can assist in any way, contact the Agency. Once everything necessary to process a claim is received, it generally takes 3 to 4 weeks to pay the claim.

Note: This is excess coverage and carries a $200. deductible.

Claims Administrator
Maksin Management Corporation
Kevon Office Center, Suite 160
2500 McClellan Avenue
Pennsauken, NJ 08109
Phone 800-257-6250
FAX 856-486-7228

Agency
William S. Payne, CLU, TB&R Insurance
P. O. Box 8767
Richmond, VA 23226
Phone 804-355-7984
FAX 804-359-9546
email: wpayne@tbrinsurance.com

MAIL CLAIM FORM TO:
MAKSIN MANAGEMENT CORP
Kevon Office Center • Suite 160
2500 McClellan Avenue
Pennsauken, NJ 08109
800-257-6250

NOTIFICATION OF INJURY

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

FOR OFFICE USE ONLY

Policy Number
Reference Number
Claim Number

CLAIM INSTRUCTIONS

When your Organization/School has selected an excess plan of insurance, benefits will be paid on the following basis:

PRIMARY EXCESS — The first $100.00 of eligible covered expenses will be paid without regard to other valid and collectible insurance. Additional eligible covered expenses will be paid only when they are in excess of other valid and collectible insurance.

FULL EXCESS — Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance. You must submit the claim to your primary insurance carrier before we can compute payment.

If the above plan descriptions do not apply to your coverage, contact the policyholder for information.

- The claim form must be submitted within 90 days from the date of injury.
- Treatment must commence within 90 days from the date of injury.
- Please have the doctor complete appropriate part on back of Claim Form.
- Include ITEMIZED outpatient bill for services showing dates for each service or treatment.
- Forward all additional bills to Agency. Please note on the bill the name of your organization and your Social Security Number. NO ADDITIONAL CLAIM FORM IS NECESSARY.
- DO NOT LEAVE CLAIM FORM AT THE HOSPITAL.
- All Benefits will be made payable to Doctors and Hospitals involved, unless accompanied by paid receipts.

"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning fact material thereto, commits a fraudulent insurance act, which is a crime."

PART I — TO BE COMPLETED BY COACH, MANAGER OR PROPERLY DELEGATED AUTHORITY

1. Name of School / Organization
2. Name of Team
3. Name of Injured Individual — Last — First — Middle Initial
4. Social Security Number
5. Birthdate
6. Date of Injury
7. Time
8. Place Injury Occurred
9. Nature of Injury (Please describe fully indicating what part of body was injured – such as broken arm, sprained ankle, etc.)
10. Describe how accident occurred. (Give all possible details.) Must be a bodily injury due to accident.

11. Did Accident Occur (Yes or No)	Yes	No
a) While claimant was supervised	☐	☐
b) During sponsored activity	☐	☐
c) During programmed hours...........	☐	☐
d) On activity premises	☐	☐
e) While traveling to or from a .... regularly scheduled activity in a supervised group.	☐	☐

12. Name of Activity / Sport

12A. (Check One) ☐ Coach ☐ Manager ☐ Player / Member

13. Name and Title of Supervisor

14. The above named claimant is a regular member of the policyholder and was injured while a regular member of such team and in the manner described above.

15. Signature (Coach, Mgr., or Delegated Authority)
16. Title
17. Date

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

PART II — TO BE COMPLETED BY CLAIMANT — OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father, Guardian or Claimant (if adult)
2. Social Security No.
3. Name of Mother, Guardian or Spouse (if adult)
4. Social Security No.
5. Address of Parents, Guardian or Claimant

5A. Telephone Number

6A. Father, Guardian or Claimant's Insurance Company(ies)

6B. Mother or Guardian or Spouse's Insurance Company(ies) Check One: ☐ Individual ☐ Group

7A. Name and Address of Father, Guardian or Claimant's Employer

7B. Name and Address of Mother, Guardian or Spouse's Employer

8. List other insurance policies under which claimant is insured

Company — Policy No.

1. ____________ 1A. ____________ ☐ Individual ☐ Group

2. ____________ 2A. ____________ ☐ Individual ☐ Group

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.

Signature of Parent or Guardian ____________ Date ____________

Authorization: I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

____________ Signature of Claimant (Parent or Guardian if a minor)

____________ Date

IF YOU HAVE AN ITEMIZED STATEMENT FROM THIS PROVIDER OF SERVICES, ATTACH THE STATEMENT(S) TO THIS FORM AND *DISREGARD* THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

Please Print or Type

1. DATE OF — *ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)*

2. DATE FIRST CONSULTED YOU FOR THIS CONDITION

3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO

Was there any congenital, predisposing or preexisting condition relevant to this injury or illness? If yes, please explain.

4. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

5. NAME OF REFERRING PHYSICIAN

IF HOSPITALIZED – GIVE NAME AND ADDRESS OF FACILITY

6. ARE THESE CHARGES BEING SUBMITTED FOR CONSIDERATION BY ANOTHER INSURANCE CARRIER?

7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, etc. OR DX CODE

1.
2.
3.
4.

8. A. DATE OF SERVICE	B. PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY:)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN *(Explain Unusual Services or Circumstances)*	D DIAGNOSIS CODE	FEE	ADMINISTRATIVE USE ONLY

9. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED *DATE*

*PLACE OF SERVICE CODES
1-(H) -INPATIENT HOSPITAL
2-(OH) -OUTPATIENT HOSPITAL
3-(O) -DOCTOR'S OFFICE

10. TOTAL CHARGE

11. PROVIDER SOCIAL SECURITY NO.

12. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

13. YOUR PATIENT'S ACCOUNT NO.

14. PROVIDER TAX I.D. NO.

15. YOUR PATIENT'S NAME

16. YOUR PATIENT'S AGE

DENTIST **MUST BE ANSWERED ON ALL DENTAL CLAIMS: Condition of Teeth prior to accident (indicate whole, sound, natural filled, capped, or artificial)**

1. DENTIST NAME
2. MAILING ADDRESS
3. CITY, STATE, ZIP
4. DENTIST SOC. SEC. OR T.I.N.* DENTIST LICENSE NO. DENTIST PHONE NO.
5. HAS TREATMENT BEEN COMPLETED? YES NO — IF NOT, WHAT MUST BE DONE AND WHEN?

	NO	YES	
6. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATE
7. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
8. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
9. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
10. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

LABIAL
Upper Right / Lingual / Left Primary Permanent / Lower
LABIAL

INDICATE MISSING TEETH WITH AN X

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER ADA CODES	FEE	ADMINISTRATIVE USE ONLY
				TOTAL FEE	$	

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED (DENTIST) ____________ DATE ______

Your Patient's Account No. –
Your Patient's Age –

MultiPlan CCN COMMUNITY CARE NETWORK

Must be furnished under Authority of Law when Benefits Assigned