PLAYERS HEALTH

ACCIDENT CLAIM FORM FOR USA SOFTBALL INSURED YOUTH TEAMS

MAIL TO: RPS Bollinger
PO Box 1322
Morristown, NJ 07960
Email: USASoftball@RPSins.com

File claims electronically: Payer ID 38259

INSTRUCTIONS: CLAIMANT SIGNATURE AND DATE MUST BE COMPLETED AT BOTTOM OF ALL THREE PAGES

Benefit Period: 52 Weeks

Policy #: PHSA-BAM-10537

SECTION I TO BE COMPLETED BY CLAIMANT

1. **NAME:** (first) _____(last) _____
2. **ADDRESS**: _____(city) _____ (state) _____ (zip code)_____
3. **TELEPHONE #:**_____ **SS#:**_____
4. **BIRTHDATE:** ___/___/___ **SEX:** Male ____ Female ____
5. **CLAIMANT IS:** Player __ Other ____ **INSURANCE PLAN (check one):** Individual Registration ___ Team Insurance ___
6. **INDIVIDUAL REGISTRATION MEMBER ID#** _____ **(INCLUDE COPY OF ID CARD)**
7. **NAME OF TEAM/LEAGUE:** _____
8. **ACCIDENT DATE:** ___/___/___ **ACCIDENT TIME:** _____ ☐ am ☐ pm
9. **BODY PART INJURED:**_____
10. **ACCIDENT OCCURRED DURING:** ☐ Game ☐ Practice ☐ Tournament ☐ Other _____
11. **DESCRIBE HOW AND WHERE ACCIDENT OCCURRED:**_____

_____

12. **NAME OF FIELD/FACILITY WHERE ACCIDENT OCCURRED:**_____

****IF THIS SECTION IS NOT FILLED OUT, CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED****

SECTION II VERIFICATION (Must be signed by Team/League Official)

I CERTIFY THAT THE ABOVE NAMED CLAIMANT IS AN INSURED MEMBER OF THE TEAM NAMED ABOVE AND THAT THE INJURY OCCURRED DURING OFFICIAL TEAM ACTIVITIES AS STATED.

NAME OF TEAM/LEAGUE OFFICIAL: _____ TITLE: _____

SIGNATURE OF TEAM/LEAGUE OFFICIAL: _____ DATE:_____

PHONE: _____

SECTION III VERIFICATION (Must be signed by USA Softball State or Metro Commissioner or Official Designated by State or Metro Commissioner)

TO THE BEST OF MY KNOWLEDGE, THE FACTS OUTLINED ABOVE ARE TRUE AND COMPLETE. I HEREBY VERIFY THAT THE CLAIMANT IS ON A TEAM THAT IS REGISTERED WITH USA SOFTBALL FOR THE CURRENT SEASON.

NAME OF USA SOFTBALL STATE/METRO COMMISSIONER: _____ TITLE: _____

SIGNATURE OF USA SOFTBALL STATE/METRO COMMISSIONER: _____ DATE: _____

PHONE: _____

Was this injury a result of an USA Softball event? [ ] YES [ ] NO If no, indicate name of Organization that held event: _____

_____ _____

Claimant Signature **Date**

SECTION IV STATEMENT OF OTHER INSURANCE (REQUIRED)

Father of Claimant

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____

ZIP:_____

PHONE:_____

EMPLOYER:_____

EMPLOYER PHONE:_____

EMPLOYED __ SELF-EMPLOYED ___ UNEMPLOYED __

EMAIL:_____

Mother of Claimant

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____

ZIP:_____

PHONE:_____

EMPLOYER:_____

EMPLOYER PHONE:_____

EMPLOYED __ SELF-EMPLOYED ___ UNEMPLOYED __

EMAIL:_____

If you are employed but have no insurance, please include a letter of verification from your employer on their letterhead stating that no insurance is provided to you through your workplace.

IS CLAIMANT COVERED UNDER ANY OTHER MEDICAL AND/OR DENTAL INSURANCE POLICY? YES ___ NO ____
IS CLAIMANT COVERED UNDER A GOVERNMENT SPONSORED INSURANCE SUCH AS MEDICARE/MEDICAID? YES ___ NO ____

****Please include a copy of insurance card (both sides)****

INSURED NAME:

_____

ID#: _____ INSURED GROUP#/NAME_____

INSURANCE COMPANY NAME:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

PHONE: _____

****ARE YOU NSURED WITH ANY OTHER SOFTBALL ORGANIZATION? YES ____ NO _____**
IF YES, INDICATE THE ORGANIZATION, CONTACT PERSON'S NAME AND PHONE NUMBER:

_____

AFFIDAVIT

I verify that the statement on the 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 the Company to the extent for which the Company would not have been liable. I consent that the Company can provide their services and communicate with me via mobile phone, messages, e-mail and any form of online communications including electronic signatures, provided that these communications comply with privacy regulations.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to Sirius America Insurance Company, its employees and authorized agents for the purpose of validation and determining benefits payable. I further authorize Sirius America or its agents to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

PAYMENT AUTHORIZATION: (Signature is required at the end of this section)

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

_____ _____

Claimant Signature **Date**

CLAIM FORM FRAUD STATEMENTS: (Signature is required at the end of this section)

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison or any combination thereof.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS. RHODE ISLAND AND WEST VIRGINIA: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: 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: 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 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.

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

DISTRICT OF COLUMBIA: WARNING: 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: 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.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: Any person who, knowing and with intent ,to defraud, presents, causes , to be presented or prepared, with knowledge or belief, that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: 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 any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA, and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defrauds, 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 RSA638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA and OREGON: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: 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.

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

NEW YORK: 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 five thousand dollars and the stated value of the claim for each such violation.

_____ _____

Claimant Signature **Date**

HOW TO FILE A CLAIM: INSTRUCTIONS

IMPORTANT: ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

1. Accident medical expenses are covered under this policy on an **Excess Basis**, and benefits will only be paid under this plan after your own personal or group insurance (including Health Maintenance Organizations) has paid out its benefits. Please note that you must follow your primary insurance carrier's eligibility criteria (i.e., to be treated in-network, if required by HMO, etc) in order for this policy to consider your expenses for payment. If you receive Government or State Aid Insurance (Medicaid, Medicare, etc) this insurance may be Primary.

   Payment under this policy will be made according to **usual and customary guidelines.** This means that the basis for payment of specific medical or dental services is based on the average cost of that service by region. This policy does not automatically pay for services in full; it pays based on the "usual and customary" fee for that service in your area.

2. **Claim Guidelines:** You have **1 year** from date of injury to submit claim form.
   For claims to be eligible for coverage, you must seek medical attention within **30 days** from date of injury.

   Benefit Period: This policy is subject to a **52 week** benefit period from date of injury. Medical or dental expenses that are incurred **within 52 weeks** of the date of injury are eligible for coverage under this policy. Any expenses or treatments that are rendered after the **52 week** benefit period will not be covered by this policy.

3. **Please remember:**
   a) Once your claim is approved, advise your Doctors/Hospitals of this insurance so they can file claims directly to Blue Water Benefit Administrators.
   b) **Itemized bills are required**: You or your providers must submit itemized bills with your primary insurance explanation of benefits (if applicable); balance due bills or notices **do not** provide the information needed to process your claim. See below for forms needed. Payments will be made to **you** if the itemized bills indicate that they have been paid. Otherwise, payments will be made directly to the doctor, hospital or other service provider.

      - **CMS-1500** is the standard form used by Providers to show the medical treatments and charges made for each service.
      - **UB-04** is the standard form used by Hospitals to show medical treatments and charges made for services.

4. **Dental bills:** All dental bills must be submitted through your primary insurance's **medical and dental plans** first before making a claims for dental treatment under this policy. Please have your provider submit an ADA dental claim form with the explanation of benefits (if applicable).

For questions regarding coverage, contact:

RPS Bollinger
Telephone: 800-446-5311
Email: USASoftball@RPSins.com

For questions regarding claim status, contact:

Blue Water Benefit Administrators
Telephone: 800-229-2210
Email: ph@bluewaterbenefitsadmin.com