

MAIL TO: NAHGA CLAIM SERVICES – 100 MAIN ST., P.O. BOX 189, BRIDGTON, ME 04009 1-800-952-4320

School District _____ School Name _____

CLAIMANT INFORMATION (must be completed)

Student's Name _____ Social Security Number _____
Last Name First Name M.I.

Current Home Address _____
Number and Street City State Zip Code Phone Number

Date of Birth _____ Male Female Grade _____

Date & time of injury _____ Nature of injury _____ Date of 1st treatment _____

Was the Student involved in a school sponsored and supervised activity at the time of injury? No Yes

If yes, under whose supervision? _____ Was He/She a witness? No Yes

If athletic, did the injury occur during: PE class Intramurals Game Practice Other _____

Type of Sport (if applicable) _____ Describe how and where accident occurred: _____

The following must be completed by school official if injury occurred during school activity

Printed Name of School Official _____ Title _____

School Official's Signature _____ Phone No. _____

PARENT (OR GUARDIAN) INFORMATION (must be completed)

Name of Mother _____

Name of Father _____

Home Address _____
Street City State Zip

Home Address _____
Street City State Zip

Home Phone no. _____

Home Phone No. _____

Employer Name _____

Employer Name _____

Employer Address _____
Street City State Zip

Employer Address _____
Street City State Zip

Employer Phone No. _____

Employer Phone No. _____

Is student covered under any other insurance policy(s)? No Yes If yes, please provide the following:

Name of Carrier _____ Policy No. _____ Name of Policyholder _____

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If other insurance exists, all claims must be submitted to the other insurance policies first. A copy of the itemized bills along with the other carrier's corresponding Explanation of Benefits should then be submitted for consideration.

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.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Fairmont Specialty or their representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original.

X _____
 Signature of Parent/Guardian or Student (if 18 years or older)

DATE _____

IMPORTANT NOTICE

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or 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 Arizona Claimants: 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.

Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Hawaii Claimants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

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 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 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 and may be subject to fines and confinement in state prison.

HOW TO FILE A CLAIM

Please follow these instructions:

- Complete front of claim form, in full;
- Sign Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to NAHGA with itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable).

All itemized bills must include:

1. Patient's Name;
2. Patient's Address;
3. Diagnosis;
4. Date of Service;
5. Description of Service (CPT Coding);
6. Medical Provider's Name, Address, Telephone Number, and Federal Tax ID Number.

- A completed claim form must be submitted for each injury a Student sustains.

**Keep copies of all claims forms, bills and correspondence for your own records.
In order for benefits to be paid, claim forms must be
filed within 90 days from the date of injury.**