USA TRACK & FIELD MEDICAL CLAIM FORM

SEND THIS FORM TO:
NAHGA CLAIM SERVICES
P O Box 189
Bridgton, ME 04009
Phone: 800-952-4320 Fax: 207-647-4569

THIS FORM SHOULD BE COMPLETED WHENEVER A MEDICAL CLAIM RESULTS FROM AN INJURY INCURRED AT A USA TRACK & FIELD SANCTIONED EVENT.

PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY

NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ M ☐ F

ADDRESS (Street) (City) (State) (Zip Code)

TELEPHONE #: ( )	OCCUPATION
USA TRACK & FIELD MEMBERSHIP #:	DATE & TIME OF ACCIDENT: ____/____/____ _____ ☐AM ☐PM

INJURED PARTY WAS:
☐Participant ☐Coach ☐Official ☐Volunteer ☐Other: _____

CLUB/ASSOCIATION NAME: COACHES NAME: PHONE #: ( )

NATURE OF INJURY

FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:

A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT:

_____

B. DESCRIBE WHERE ACCIDENT HAPPENED:

_____

C. DESCRIBE HOW ACCIDENT HAPPENED:

_____

D. DID THE ACCIDENT OCCUR DURING: ☐ SANCTIONED COMPETITION ☐ REGISTERED CLUB PRACTICE ☐ TRAVELING TO/FROM

☐ OTHER:_____

E. WITNESS NAME: PHONE #:

IF INJURED PARTY IS A MINOR:

PARENT/GUARDIAN NAME: _____ HOME PHONE #:_____

EMPLOYER NAME: WORK PHONE #:

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? ☐ YES ☐ NO

IF YES, NAME OF INSURANCE COMPANY	POLICY #

ADDRESS (Street) (City) (State) (Zip Code)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to American Specialty Insurance & Risk Services, Inc., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)	DATE

AUTHORIZATION TO PAY PROVIDER – I authorize payment associated with this incident directly to the physicians or providers.	IF YES, SIGNATURE	DATE
I certify that the foregoing information is true and correct.	SIGNATURE	DATE

THE ISSUANCE OF THIS BLANK REPORT FORM IS NOT AN ADMISSION OF THE EXISTENCE OF ANY INSURANCE, NOR DOES IT RECOGNIZE THE VALIDITY OF ANY CLAIM, AND IS WITHOUT PREJUDICE TO THE COMPANY'S LEGAL RIGHTS IN THE PREMISES.

USA TRACK & FIELD
MEDICAL CLAIM FILING INSTRUCTIONS

1. DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA TRACK & FIELD.
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital, or other providers' standard insurance billing forms: HCFA from physician or UB 04 from hospital. These forms must show the following:

   *PATIENT'S NAME
   *CONDITION/DIAGNOSIS
   *TYPE OF TREATMENT
   *DATE EXPENSE INCURRED
   *CHARGES

4. Attach an Incident Report form.
5. Your coverage is an excess policy unless there is no other insurance in place. This policy has a $200 deductible. Other policy information can be found at www.usatf.org/membership/benefits/groupinsurance.asp. Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces, or other coverage.
6. To expedite proper processing, submit the Medical Claim Form completed in full, along with the documents outlined/required above, to the following address:

Nahga Claim Services
P O Box 189
Bridgton, ME 04009

or email to claims@nahga.com or fax to 207-647-4569

IMPORTANT CLAIM NOTICE

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

District of Columbia: 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.

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.

Kentucky Residents: 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.

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

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

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

Ohio Residents: 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.

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.

For All States Other Than The Above: 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.

SIGNATURE OF INJURED PERSON (OR PARENT/GUARDIAN IF MINOR) DATE