



MultiPlan for Facilities Referral

Call 800-557-8794

1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
 3. MAIL TO
- E-mail : claims@hsri.com

HSR

Health Special Risk, Inc.

HSR Plaza
4001 N. Josey Lane
Carrollton, Texas 75007
Phone: (972) 492-6474 Fax: (972) 492-4946
Underwritten by : ACE American Insurance Company

Preferred Plan
"The Network of Choice."

Policy Number: _____

School Name (if applicable): _____

PART I – POLICYHOLDER’S REPORT

1. NAME OF POLICY HOLDER	2. ADDRESS OF POLICY HOLDER Street _____ City _____ State _____ Zip _____
---------------------------------	---

3. NAME OF INSURED PERSON	4. SOCIAL SECURITY NUMBER - -	5. SEX _F_ _M_	6. BIRTHDAY _ / _ / _
----------------------------------	---	--------------------------	---------------------------------

7. ADDRESS OF INSURED PERSON Street _____ City _____ State _____ Zip _____
--

8. PARENTS’ NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE)

9. DATE AND TIME OF ACCIDENT	10. PLACE WHERE ACCIDENT OCCURRED	11. WAS INSURED A PARTICIPANT, STAFF MEMBER, GUEST OR VOLUNTEER?
-------------------------------------	--	---

FOR DENTAL CLAIMS ONLY	12. INDICATE WHICH TEETH WERE INVOLVED IN THE ACCIDENT 13. DESCRIBE CONDITION OF INJURED TEETH PRIOR TO ACCIDENT: <input type="checkbox"/> WHOLE, SOUND AND NATURAL <input type="checkbox"/> FILLED <input type="checkbox"/> CAPPED <input type="checkbox"/> ARTIFICIAL
-------------------------------	---

14. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)
--

15. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT

16. DID ACCIDENT OCCUR (CIRCLE YES OR NO) FOR EACH OF THE FOLLOWING:		
A. During a policyholder sponsored & supervised activity?	YES	NO
B. During programmed hours?	YES	NO
C. On activity premises?	YES	NO
D. While on the job (if applicable)?	YES	NO
E. While traveling directly and uninterruptedly to or from home and policyholder premises?	YES	NO
F. During intercollegiate/scholastic athletic practice? YES NO or competition?	YES	NO
G. During a USGF sanctioned event? (Gymnastics schools only)	YES	NO

17. NAME OF EVENT OR ACTIVITY:	18. NAME & TITLE OF SUPERVISOR
---------------------------------------	---

19. SIGNATURE OF POLICYHOLDER REPRESENTATIVE	20. TITLE	21. DATE
---	------------------	-----------------

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? YES NO
 If Yes, name of insurance company _____ Policy # _____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? YES NO
 If Yes, name of insurance company _____ Policy # _____

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
 Name of Insurance Company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	WITNESS	DATE
---	----------------	-------------

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.
SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

FLAHD STATEMENTS

GENERAL: 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.

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

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: 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 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.

DELAWARE: 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 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: 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.

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

INDIANA: Any 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.

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.

MARYLAND: 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, commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

NEW HAMPSHIRE: 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 RSA 638:20.

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

NEW MEXICO: 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 civil fines and criminal penalties.

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.

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.

OREGON: 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 material fact, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA: Any person who, with the 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 may have violated state law.

HIPPA Authorization for Use and Disclosure of Information

I hereby authorize the use and/or disclosure of my individual identifiable health information (the “information”) as follows:

In connection with the insurance claim on the accompanying Proof of Loss Form dated _____ (the “Claim”), I authorize my health care providers to disclose to Health Special Risk, Inc./NAIU Claims, my sponsoring College or University, and/or any insurance companies to whom the claim may be submitted (a “Payor”), all information related to the Claim, for the specific purposes of facilitating the processing and/or payment of the claim by Health Special Risk, Inc. /NAIU Claims and communicating with Health Special Risk, Inc. /NAIU Claims and the Payor about the claim.

This authorization is specifically limited to the individually identifiable health information related to the Claim.

I further understand and agree:

1. This authorization will expire upon the termination of the insurance policy between my sponsoring college or university and the Payor.
2. I may revoke this authorization at any time by notifying Pan Health Special Risk, Inc. /NAIU Claims in writing (although the revocation will not have any effect on any actions taken before receiving the revocation).
3. I may see and copy the information described on this form if I ask for it.
4. I am not required to sign this form in order to receive health care services from my provider.
5. The information that is used or disclosed under this authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

If I am signing this Authorization as a Claimant’s Representative, I certify that I have the authority to act on behalf of the Claimant and that the information provided below to verify my identity is correct.

Signature of Claimant or Claimant’s Representative

Date

Name of Claimant’s Representative, if applicable: _____

Representative’s Date of Birth: _____

Relationship to the Claimant: _____