≠National Union Fire Insurance Company of Pittsburgh, Pa.

COVERAGE VERIFIED

PLEASE PRINT ALL INFORMATION

MAIL TO:
Maksin Management
CN85000
Pennsauken, NJ 08110-5000
1-877-775-5430

CLAIM FORM

COMPLETE IN DETAIL TO INSURE PROMPT HANDLING

SPECIAL NOTICE: 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.

PART 1 – MUST BE COMPLETED AND SIGNED

Name of School	Jackson State University	Policy Number	Birth Date
Insured's Name		AMH0043736	
	LAST NAME / FIRST NAME / M.I	INSURED'S SOCIAL SECURITY #	PHONE

Present Address _____
NO. AND STREET / CITY OR TOWN / STATE / ZIP + 4

Home Address _____
NO. AND STREET / CITY OR TOWN / STATE / ZIP + 4

If claim for dependent, give dependent's name _____ , relationship to insured _____ D.O.B. _____

MUST BE COMPLETED

Are you covered (as an insured or dependent) by any other hospital and/or medical plan? ☐ Yes Insured ☐ Yes Dependent ☐ No

If yes, please check one: ☐ Group ☐ Individual ☐ Automobile/Medical

If yes, also indicate name and policy number of insurance company.

Name of Insured: _____ Policy #/Group #: _____ I.D. # _____ Company _____

Have you filed a claim with the above company? ☐ Yes ☐ No

Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.

Name and Address of Employer of:

☐ Insured, if employed _____

☐ Spouse, if insured is married _____

1. Date of accident or sickness		Date of first treatment.	
2. Nature of sickness or injury.			
3. If injury, describe how and when accident occurred and indicate if work related			
*4. If injured in practice or play or sport, indicate which sport.		Check One:	☐ Intramural ☐ Intercollegiate ☐ Other
5. Have you previously been troubled with this condition?	☐ Yes ☐ No Date _____		
6. Give name of all other physicians consulted			
7. Hospitalized? If so, where and what dates	Where?	From: _____ To: _____	
8. Health Center referral?	☐ Yes ☐ No If yes, attach referral to claims form. If no, please explain _____		

PAYMENT WILL BE PAID 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

*** IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICAL**

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision

DATE

Signature of College Official _____ **Title** _____ **Date** _____

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit *(while my claim is pending)* the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization *(one or which will be given to me by the Company upon my request)* will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

STREET / CITY / STATE / Zip + 4

PART II – ATTENDING PHYSICIAN'S STATEMENT

AUTHORIZATION: I hereby authorize the Company, or the designated claims administrator to inspect or secure copies of case history records, laboratory reports, diagnoses, prognoses, and any data covering this or other confinements and disabilities.

DOCTOR, PLEASE SIGN _____ **DATE** _____

EACH DOCTOR'S BILL ATTACHED MUST BEAR THE DOCTOR'S I.D. OR SOCIAL SECURITY NUMBER

1. Nature of sickness or injury. Describe any complications	
2. If fracture or dislocation, state whether reduced or immobilized. If fractures of long bones, state whether fracture is though shaft or extremity. Was it confirmed by X-ray?	☐ Yes ☐ No
3. When did symptoms first appear or accident happen?	Date _____ , _____
4. When did patient first consult you for this condition?	Date _____ , _____
5. Has patient ever had same or similar condition? If yes, state when and describe.	☐ Yes ☐ No Date _____ , _____
6. Describe any other disease or infirmity affecting present condition.	
7. Nature of any surgical or obstetrical procedure. Describe fully. Include CPT Code. Where and when performed?	Date _____ If in hospital, in patient ☐ out-patient ☐
8. Give dates of treatment.	
9 Is condition a result of or in any way connected with pregnancy?	☐ Yes ☐ No Inception date of pregnancy: _____
10. Is patient still under your care for this condition? If discharged, give date.	☐ Yes ☐ No Discharge date _____ , _____
11. If patient hospitalized, give name and address of hospital.	Hospital City State Date admitted _____ , _____ Date discharged _____ , _____
12. Did you file this claim with any other Insurance Company? If yes, indicate name and address of Company.	Name _____ ☐ Yes ☐ No Address

Signed: _____ **Degree** _____ **Date** _____

S.S # _____ **THIS MUST BE INCLUDED** **Phone #** _____

ADDRESS: _____

STREET CITY STATE ZIP + 4

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITOIN TO THOSE ABOVE

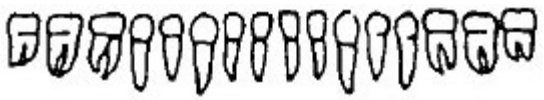
1. State exactly which teeth were involved in the accident and indicate them on chart

_____

_____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



2. Describe exact nature of injury.

_____

_____

3. Describe condition of injured teeth prior to accident:

☐ Whole, sound and natural

☐ Filled ☐ Capped ☐ Artificial

4. Comments:

_____

_____

_____

IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment accompanied by all bills incurred to that date.