

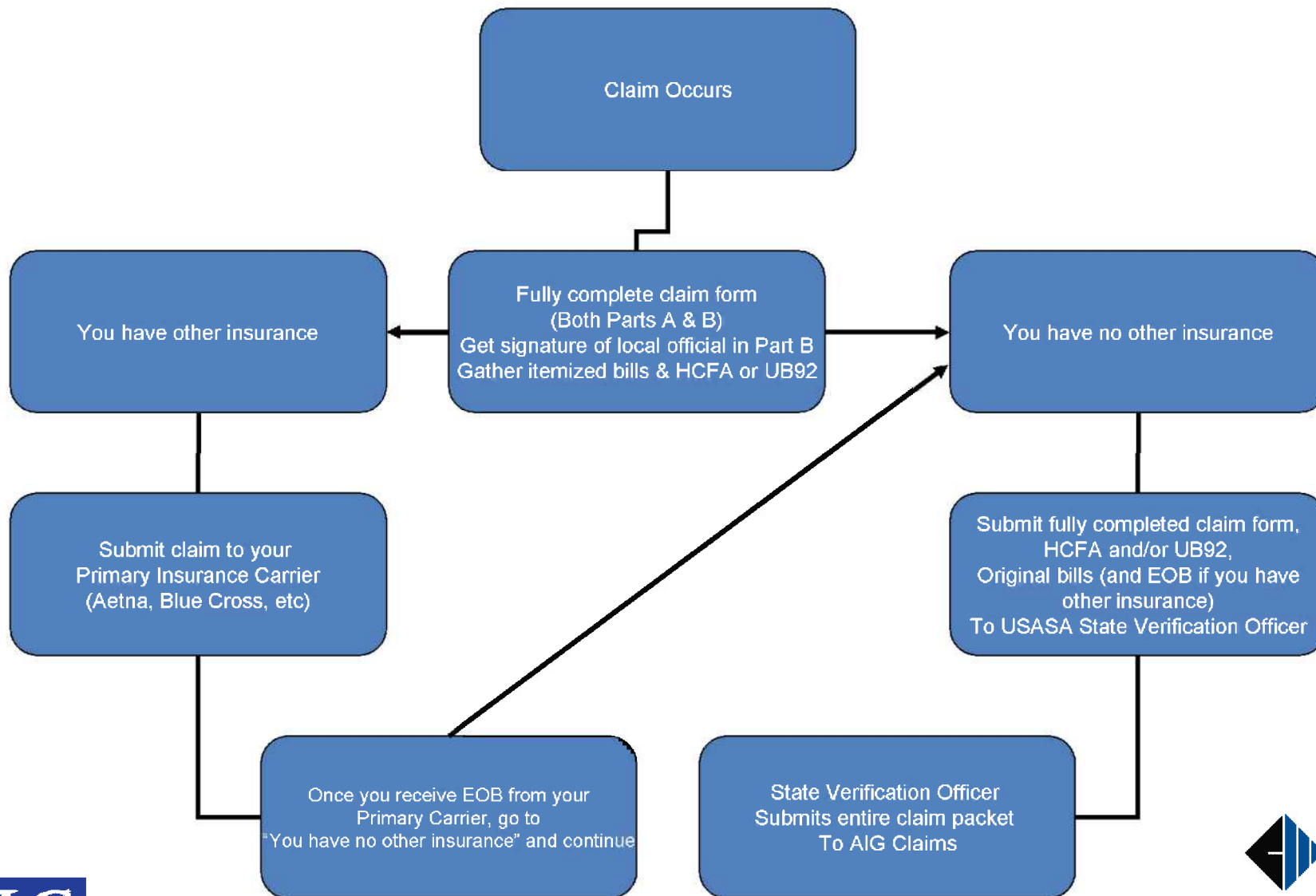


CLAIMS FILING INSTRUCTIONS FOR USASA ACCIDENT POLICIES

Effective 9/1/2008



Claim Filing Process Overview





Step By Step Instructions



- 1) You have been provided with a claim form that is designed specifically for USASA. Please use only this form. Do not delay submitting this form: it must be received with or without attachments, within 90 days from the date of the accident or benefits may be denied due to untimely filing.

Signature of Claim verification officer: _____ Date: _____

CLAIM PROCEDURE U.S.A.S.A. SPECIAL REI ACCIDENT CLAIM FORM - Please print the name of the injured person.

1. Fill out this form as soon as possible after the accident. This form must be received with all attachments within 90 days from the date of the accident. It is not to be used for any other purpose.
2. Do not delay submitting this claim form. This form must be received with all attachments within 90 days from the date of the accident. It is not to be used for any other purpose.
3. Complete this form as soon as possible after the accident. This form must be received with all attachments within 90 days from the date of the accident. It is not to be used for any other purpose.
4. Complete this form as soon as possible after the accident. This form must be received with all attachments within 90 days from the date of the accident. It is not to be used for any other purpose.

Completed this form on: _____
 Name of the injured person: _____
 Address: _____
 City: _____ State: _____ Zip: _____

USASA **AIG**

PART A - This section MUST be completed, signed and dated by the injured person, or his/her Parent or Guardian (If the injured person is under the age of 18 or absent or dependent)

Name of injured person (Print name)	Date of accident (Month/Day/Year)
Address (Print name and address)	City (Print name)
State (Print name)	Zip (Print name)
Age (Print name)	Sex (Print name)
Occupation (Print name)	Employer (Print name)

PART B - This section MUST be completed, signed and dated by an official of your local organization.

Name of local organization (Print name)	Date of accident (Month/Day/Year)
Address (Print name and address)	City (Print name)
State (Print name)	Zip (Print name)
Name of official (Print name)	Title (Print name)

AUTHORIZATOR

I hereby authorize the insurance carrier to investigate the accident and to take any action necessary to process the claim. I understand that this authorization is irrevocable and that I will be held responsible for any action taken by the insurance carrier. I understand that this authorization is irrevocable and that I will be held responsible for any action taken by the insurance carrier.

Signature of the injured person: _____
Date: _____

Signature of the parent or guardian: _____
Date: _____

Signature of the official: _____
Date: _____





Step By Step Instructions

(Continued)



2) Part A must be fully completed and signed by the participant or his/her legal guardian.

PART A - This section MUST be completed, dated and signed by the Injured Person - or by his/her Parent or Guardian if the Injured Person is under the age of 18 or otherwise dependent.	
1. Name of Injured Person (insured): <i>First/Middle/Last</i>	1a. Date of Accident: <i>Mo/Day/Year</i>
2. Complete Mailing Address: <i>Street/City/State/Zip</i>	
3. Area Code/Home Ph#:	3a. Area Code/Work Ph#:
4. Social Security #:	5. Date of Birth <i>Mo/Day/Year</i>
6. <input type="checkbox"/> Male <input type="checkbox"/> Female	6a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Full-time Student
7. Are you currently enrolled in any health insurance and/or soccer accident plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, all bills must be submitted to them first for consideration. If no, see lines 7a and 7b.	
Company Name: _____ Group Name: _____ Policy Number: _____	
Company Name: _____ Group Name: _____ Policy Number: _____	
7a. If you are not enrolled in any health insurance plan, we require written verification from your employer and your spouse's employer (if applicable), or Bursar's office if you are a full-time college student.	
7b. If you are self-employed or unemployed and not covered under any health insurance plan, please sign below.	
Signature of Player: _____	





Step By Step Instructions

(Continued)



3) Part B must be fully completed, signed and dated by a local team/USASA organization official.

PART B - This section MUST be completed then signed by an official of your local organization.	
1. Team name:	
2. League name:	
3. State:	3. a. Region:
4. Injury occurred at: Event Practice Travel Game	
4.a. Name of event:	
4.b. Injury occurred on: Indoor Field Outdoor Field	
5. Describe how accident occurred:	
6. Type of injury:	
7. Name and Phone Number of coach, manager or referee present at the time of the accident:	
8. Signature of local official:	Title:





Step By Step Instructions

(Continued)



<input checked="" type="checkbox"/>	ABC Hospital & Clinic	
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>	Patient: John Valdez	Date: 05/06/03
<input checked="" type="checkbox"/>	Condition: Leg Injured Playing Soccer	
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>	05/06/03 54555 MED HISTORY & PHYSICAL EXAM	83.00
<input checked="" type="checkbox"/>	05/06/03 77767 XRAY LEG PA AND LAT	91.00
<input checked="" type="checkbox"/>	05/07/03 32333 CBC WITH 5-PART WBC	35.50
<input checked="" type="checkbox"/>	05/07/03 44434 PROTEIN TOTAL, SERUM	24.00
<input checked="" type="checkbox"/>	Total Charges	233.50
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>		
	<input type="text"/>	<input type="text"/>

4) **Submit** itemized insurance billing forms.* These forms are available from your health care provider and include the patient's name, condition (diagnosis), type of treatment and date the expense(s) was/were incurred.

“Balance due” statements are not acceptable.

**HCFA 1500 form for physicians, UB92 form for facilities (i.e, hospitals).*





Step By Step Instructions (Continued)



5) If you have medical coverage under another policy you must submit the bills to your primary insurer first and submit a copy of your primary insurer's Explanation of Benefits (EOB) statement along with the claim form to your State Verification Officer.



