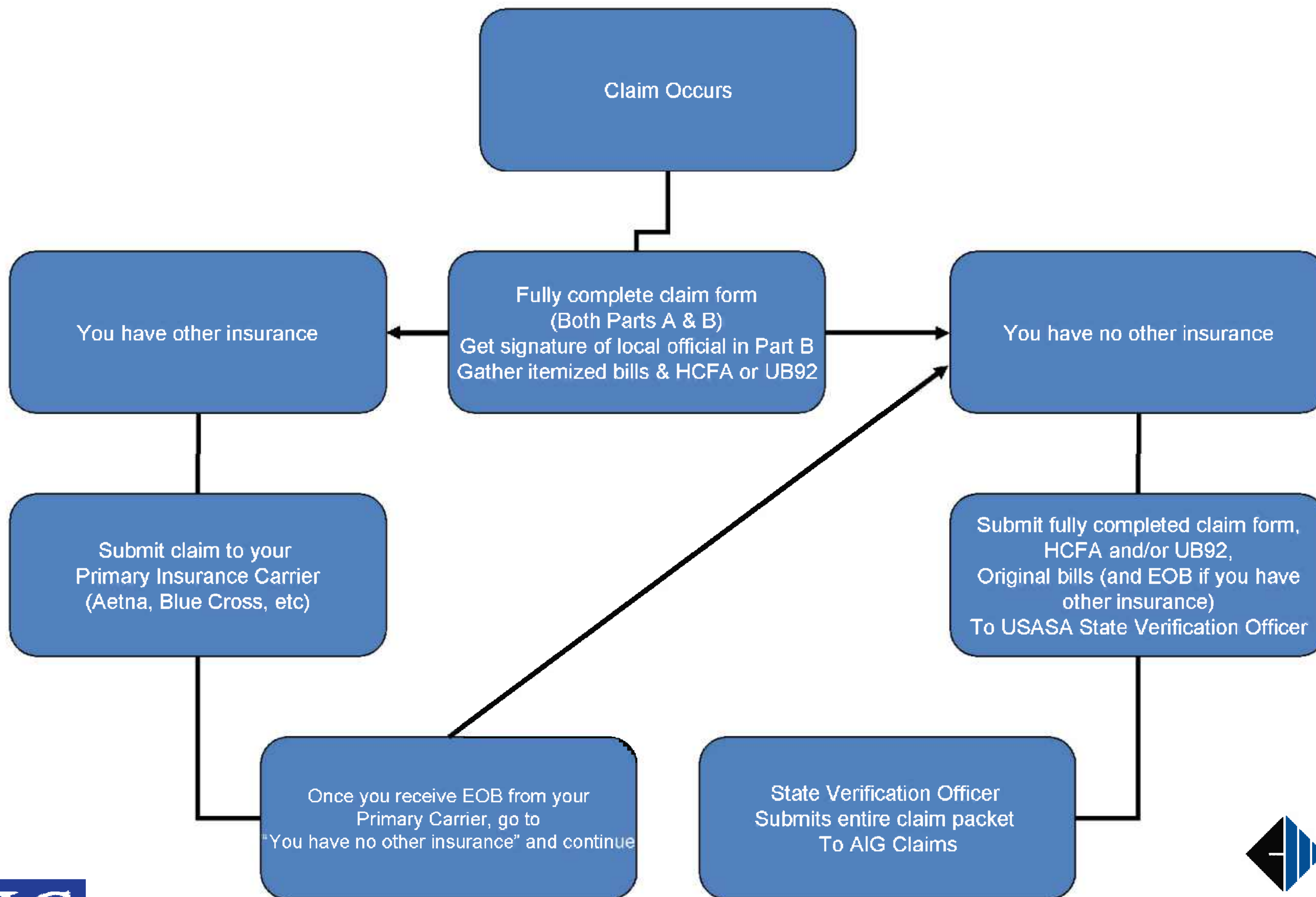
CLAIMS FILING INSTRUCTIONS FOR USASA ACCIDENT POLICIES

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.

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): *First/Middle/Last*	1a. Date of Accident: *Mo/Day/Year*
2. Complete Mailing Address: *Street/City/State/Zip*	
3. Area Code/Home Ph#:	3a. Area Code/Work Ph#:
4. Social Security #:	5. Date of Birth: *Mo/Day/Year*
6. ☐ Male ☐ Female	6a. ☐ Single ☐ Married ☐ Full-time Student

7. Are you currently enrolled in any health insurance and/or soccer accident plan? .... ☐ Yes ☐ 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)

ABC Hospital & Clinic

Patient: John Valdez   Date: 05/06/03

Condition: Leg Injured Playing Soccer

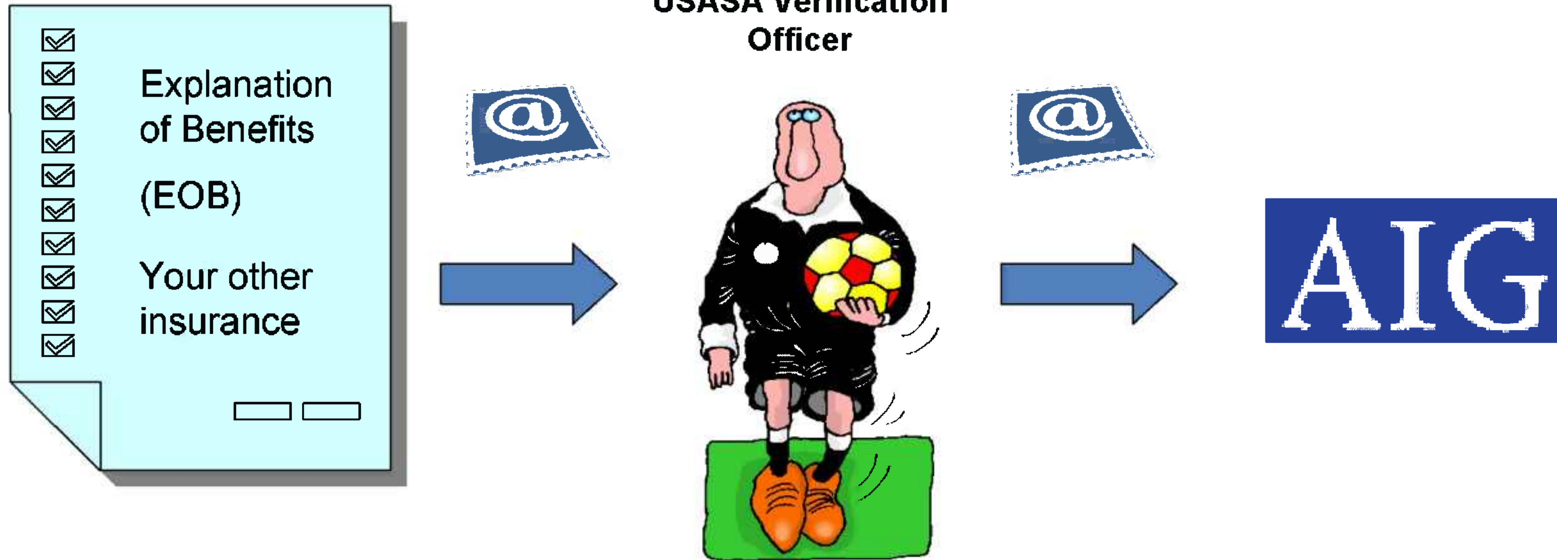
05/06/03 54555 MED HISTORY & PHYSICAL EXAM	83.00
05/06/03 77767 XRAY LEG PA AND LAT	91.00
05/07/03 32333 CBC WITH 5-PART WBC	35.50
05/07/03 44434 PROTEIN TOTAL, SERUM	24.00
Total Charges	**233.50**

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.