MAIL TO:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
www.acitpa.com

CLAIM FORM

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Group Plan or Program: _____ (Policyholder) _____ (Policy Number) _____ (Certificate/I.D. Number)

Name of Insured Individual: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Present Address: _____ (No. and Street) _____ (City or Town) _____ (State) _____ (Zip Code Country)

Home Address: _____ (No. and Street) _____ (City or Town) _____ (State) _____ (Zip Code Country)

Telephone Number: _____ Date of Birth: _____ Male ☐ Female ☐ (Circle One)

Date of Accident or Sickness:	Nature of Accident or Sickness:

If accident, describe fully how and where accident occurred:

If injured in play or practice of sport, indicate what sport:

Is the insured covered under any other group plan, health maintenance organization, government plan, or insurance policy?
Yes ☐ No ☐ Insurance Company: Policy Number:

Are you covered as a dependent under this policy? Yes ☐ No ☐

Are you covered under your school's domestic student accident and sickness insurance plan? Yes ☐ _____ (Name of School) No ☐

INSURED OR PARENT MUST SIGN BELOW:

_____

Authorization: I hereby authorize release to Administrative Concepts, Inc., any and all information concerning advice, care or treatment provided to myself or any of my family which may be needed to process this claim.

INSURED OR PARENT MUST SIGN BELOW AUTHORIZING PAYMENT TO:

☐ Medical Provider
☐ Third Party: Name: _____
Address: _____
Relationship to insured: _____

Authorization: I hereby authorize payment of medical benefits to the medical provider or third party identified on this form, for the service described.

Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

Insured's Signature: Date:	Insured's Signature: Date:

Physician or Provider Information (Please Attach Universal 1500 Form or Fill Out In Full Below)

Date of First Symptom of Illness or Injury: _____ Date First Consulted you for This Condition: _____ Has Patient Ever Had Same or Similar Symptoms? Yes ☐ No ☐

Diagnosis History of Illness or Injury

Name of Referring Physician or Other Source:

For Services Related to Hospitalization (Give Date) Admitted: _____ Discharged: _____

Name and Address of Facility Where Services Rendered: Was Laboratory Work Performed Outside Your Office? Yes ☐ No ☐ Lab Charges:

Date of Service	Place of Service	CPT Code	Description of Service	ICD-9	Charge

Will You Accept Assignment?: Yes ☐ No ☐ Total Charges: _____

_____ (Providers Signature) _____ (Date)

_____ (Print Providers Name) Providers Address _____

Tel. #: _____
Fax #: _____
Tax I.D. # _____

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?
☐ Yes ☐ No

If yes, indicate the name and address of the company _____

Effective date of coverage: _____ Expiration date: _____ Policy No. _____

Have you filed a claim with any other insurance company? ☐ Yes ☐ No

I hereby 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 _____

or Legal Designation _____

Please complete the following if you are insured under the medical insurance plan of a parent or spouse.

Mother's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

Father's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

Spouse's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:
Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California , Louisiana, New Mexico and Texas : presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or 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, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** 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.

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

Ohio: 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.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
WARNING:
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.

District of Columbia, Tennessee and Virginia : It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

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.