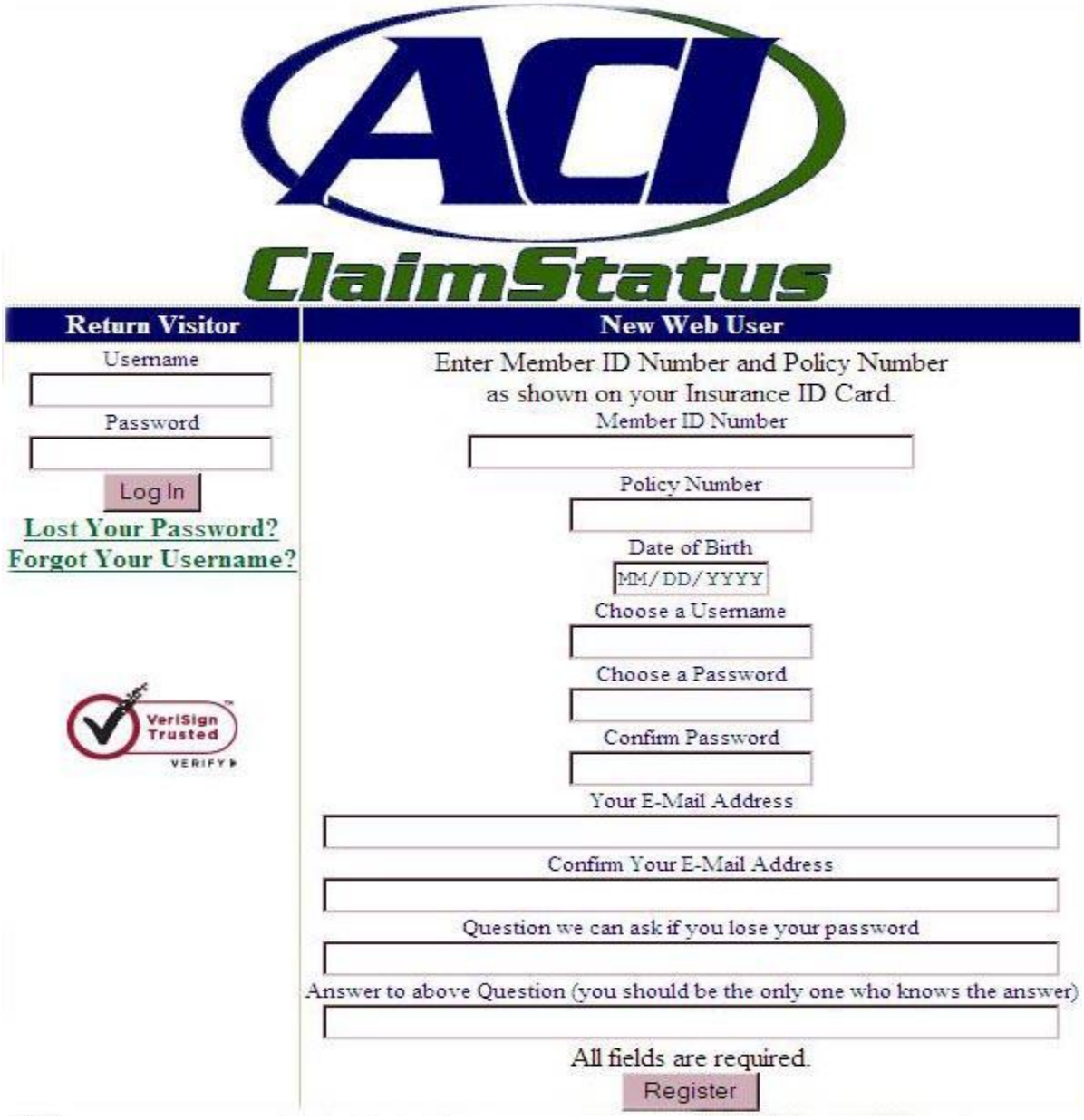
ADMINISTRATIVE CONCEPTS, INC.

*994 Old Eagle School Road • Suite 1005 • Wayne, PA 19087 • Telephone: (888) 293-9229 • Fax: (610)293-9299 • www.visit-aci.com*

***Claim Status Instructions***

1) Go to ACI's website: www.visit-aci.com
2) Click on "Claim Status"
3) Click on "Insured"
4) Below is the screen that will appear. Enter the required information to setup a username and password or on the left side of the page, enter your username and password for your existing account.
5) Once logged in, on the left hand side of the page you will find the option to view "Claims".



**MAIL TO:**
*Administrative Concepts, Inc.*
*994 Old Eagle School Road*
*Suite 1005*
*Wayne, PA 19087-1802*
*www.visit-aci.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. # _____

2013

# 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.

**MultiPlan Provider Network**

ACI has joined forces with MultiPlan, Inc. to bring you the MultiPlan Provider Network. You have access to nearly 700,000 quality healthcare professionals and 4,800 hospitals, plus two ways to keep your medical costs in line:

1. Whether in or outside the local area, a MultiPlan logo on your insurance card tells you and your provider that a MultiPlan discount applies.
2. Your out-of-pocket costs will be based on your plan's coinsurance levels, but you benefit from significantly discounted claim costs.

## HOW DO I FIND A DOCTOR?

We can help you find the provider of your choice. Simply call **800-464-0292** Monday through Friday from 8 a.m. to 8 p.m. (Eastern Standard Time) and identify yourself as a health plan participant accessing MultiPlan Network. You may also search online at **www.multiplan.com**:

• Click on the "Search for a Doctor or Facility" button
• Indicate that you have the logo shown here on the front of your ID card
• Follow the prompts to enter your search criteria

**Before your appointment**

It is your responsibility to confirm your providers' continued participation in the MultiPlan Network and accessibility under your benefit plan. Please also be sure to follow any required preauthorization procedures (usually a telephone number on your ID card), and always present your benefits ID card upon arrival at your appointment.

**If you need assistance**

If you encounter issues when scheduling appointments with the MultiPlan Network providers, call **800-464-0292**.

Please note: Multiplan, Inc. and its subsidiaries are not insurance companies, do not pay claims and do not guarantee health benefit coverage. For information about your benefits, please refer to your health plan booklet or contact ACI.

## HOW DO I FILE AN INSURANCE CLAIM?

**The Process**

- **Download** a claim form from www.visit-ACI.com
- **Follow the instructions** on the claim form
- **Fill out** the claim form completely
- **Be descriptive** in regards to the service the doctor performed. Past medical history, dates of the condition and/or symptoms were first experienced and addresses of prior physicians. Remember, if a question applies to your particular situation, please answer it! Please make sure to include your email address.

**Claim Reimbursement Request**

- **Attach** your paid receipt, itemized bills, statements and invoices for services and supplies.
  - Please make sure that all documents indicate claimants name, date of service, diagnosis and the itemized charges.
  - If you are requesting the payment on behalf of someone else such as for your parents or a minor child, please write that the payment should be made out to you. Add payment information to the claim form itself, or attached a separate cover letter with explanation.

**Mail the claim form** and the accompanying documents to the address listed in the top right hand corner of your claim form. **Or by email at: aciclaims@visit-aci.com**

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Within the US & Canada: 1-888-293-9229
Outside the USA & Canada: 1-610-293-9229
Fax: 1-610-293-9299

The claim form can be found at www.visit-ACI.com (*Insured* ➧*Claim Form* ➧ *RCM&D Accident & Sickness*). You may also fax or email the documentation to 610-293-9299 if the information is clear & legible and does not appear to be altered.

## RX

When submitting prescription drug charges for reimbursement, you are required to send more than a cash register receipt. Please submit the Pharmacy receipt listing the Pharmacy name, your name, date, drug, and amount dispensed.

## TIPS

- Keep copies of all the documents submitted. There is no guarantee that your submission will always make it to our office via postal service.
- You need to submit a new claim for each family member and for each new medical condition being treated.
- You need to file the claim within 90 days. However, you are recommended to file as soon as you avail the medical service.
- After you submit the claim, you should follow up with ACI periodically to make sure the process is going smoothly.

➢ If you want someone to speak with ACI on your behalf by calling (888)293-9229, please complete an "Authorization to Disclose Personal Health Information" and submit to ACI. This form can be found on the ACI website www.visit-ACI.com (*Insured* ➧ *Authorization*).

## Claim Processing Procedure

The insurance company will process complete claims within 2 to 4 weeks after receiving the claim information. If additional information is required, you will be informed with the explanation of benefits (EOB). You should follow the instructions carefully and arrange for the documents to be submitted back to the requestor. Many claims are pending for a long time solely because the insurance company is waiting for the provider to send medical documentation. Please follow up with your provider to make sure that they have provided the required information.

Once the claim is processed, for all eligible claims, ACI will make the payment. If you paid at the time of service, reimbursement will be made to you.

In either case, you will receive and EOB that will describe the services rendered and filed for the claim, what charges were covered, what charges were not covered and why. The EOB may also list your due amount that you should pay to the provider if you have not already paid.

All claims (original medical bills, completed claim form, and original receipt for prescription charges, if applicable) should be submitted to:

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www.visit-ACI.com
Within the US & Canada: 1-888-293-9229
Outside the USA & Canada: 1-610-293-9229
Fax: 1-610-293-9299
**Or by email at: aciclaims@visit-aci.com**

If you have any questions concerning claims processing, please contact the ACI office.
It is the Insured Person's responsibility to make sure that the claim form, original bills, supporting claim documentation, etc. are submitted timely and completely.

## AXA Assistance USA

One of the benefits to your insurance plan is the inclusion of Assistance Services provided by AXA Assistance. AXA Assistance is available 24 hours per day, 7 days per week, and you are encouraged to call them for any and all medical emergencies. They may be reached toll-free at 1-855-327-1414 or from overseas call direct or collect to 1-630-694-9764. AXA Assistance *must be involved in any Emergency Medical Evacuation, Emergency Reunion or Repatriation of Remains procedures.* In addition, AXA Assistance may be of assistance in locating medical providers in the area of the world the Insured Person will be visiting.

E-Mail: medassist-usa@axa-assistance.us