Arch Insurance Group®

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

# *ARCH Insurance Company*
# *CLAIM FORM*

**COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING**

Any person who knowingly presents a false or fraudulent claim for payment of 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.

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)

If payment is to be made to someone other than the Insured, who is to receive payment? _____

Relationship to insured: Address:

| 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 ❑

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.

IF PAYMENT IS TO BE ASSIGNED TO PROVIDER, SIGN BELOW:
Authorization: I hereby authorize payment of medical benefits to the medical provider 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: Insured's Signature:

Date: 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 |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

_____ (Provider's Signature) _____ (Date) Will You Accept Assignment?: Yes ❑ No ❑ Total Charges: _____

_____ (Print Provider's Name) _____ (Provider's 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 _____

**The following section is applicable if you are covered under any other medical insurance plan.**

Mother's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Father's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Spouse's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

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

**California:** For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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.

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

**Florida:** and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any 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 material fact 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.

**Louisiana, New Mexico, Texas and West Virginia:** presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA**: 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.)

**Maryland:** and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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.

**Oregon:** and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

**Puerto Rico:** and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**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.

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

**Maine/Washington:** 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.

**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. Penalties include imprisonment, fines and denial of insurance benefits.