G·T·L

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

BOTH SIDES OF CLAIM FORM MUST BE COMPLETED AND RETURNED WITH ITEMIZED BILLS WITHIN 30 DAYS.

EDI PAYOR ID# 22384

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.

-PLEASE PRINT ALL INFORMATION-

PARTS I & II MUST BE COMPLETED AND SIGNED BY STUDENT

Name of Group, City and State | Graduate ☐ Undergraduate ☐ Domestic ☐ International ☐ | Policy Number | Birth Date

Insured Member's Name _____ (LAST NAME / FIRST NAME / MIDDLE INITIAL) | MEMBER ID# | PHONE #

Present Address _____ (NO. AND STREET / CITY OR TOWN / STATE / ZIP CODE + 4)

Home Address _____ (NO. AND STREET / CITY OR TOWN / STATE / ZIP CODE + 4 / NAME OF HOME COUNTRY)

If claim for dependent, give dependent's name _____ relationship to Insured _____ Age _____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Nature of Injury (Describe fully, including which part of body was injured.) _____

Describe How, When and Where Accident Occurred (Include Date and Time) _____

Was the injury due to practice or play of a sport? ☐ Yes ☐ No

Which Sport?
☐ Intercollegiate ☐ Intramural ☐ Club ☐ Other

Is condition work related? ☐ Yes ☐ No

Is condition due to auto accident? ☐ Yes ☐ No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition?
☐ Yes ☐ No
Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ☐ Yes ☐ No
If not, why? Away from school
For what reason: _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of Sickness _____

Date symptoms first noticed _____

What is the exact nature of the sickness _____

If pregnancy, date of last menstrual period _____

Have you ever had the same or similar condition? ☐ Yes ☐ No
If yes, date of first treatment _____

Date of last treatment _____

Were you treated in the Health Service for this condition?
☐ Yes ☐ No
Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ☐ Yes ☐ No
If not, why? Away from school
For what reason: _____

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.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____ (STREET / CITY / STATE / ZIP CODE + 4)

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. _____

Dear Insured: Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.

Arkansas	**Kansas**	**North Carolina**	**South Dakota**
California	**Louisiana**	**North Dakota**	**Texas**
Connecticut	**Massachusetts**	**Nebraska**	**Utah**
Georgia	**Michigan**	**Nevada**	**Vermont**
Iowa	**Missouri**	**Puerto Rico**	**Wisconsin**
Illinois	**Mississippi**	**Rhode Island**	**West Virginia**
	Montana	**South Carolina**	**Wyoming**

Generic Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska, Delaware, Idaho, Indiana, Oklahoma - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Colorado, Washington D.C., Hawaii, Maine, Tennessee, Virginia - 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 coverage.

Arizona, Minnesota, New Jersey, New Mexico - Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

Kentucky, Ohio, Oregon - Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

Florida - Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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 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.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files 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 and subjects such person to criminal and civil penalties.

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

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