SEE REVERSE SIDE FOR DETAILED CLAIM FORM FILING INSTRUCTIONS

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Accident Medical Expense Insurance for Diocesan Volunteers

CLAIM FORM

PART A SCHOOL/PARISH STATEMENT

NAME OF VOLUNTEER FIRST	MI	LAST	AGE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO / DAY / YR

NAME OF SCHOOL/PARISH	NAME OF DIOCESE/ARCHDIOCESE

SCHOOL/PARISH MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF INJURY/SICKNESS MO / DAY / YR	TIME OF INJURY : ☐☐ (CIRCLE ONE)	WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT	HAS THE VOLUNTEER SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY	WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO	DATE SCHOOL/PARISH WAS NOTIFIED / /

NAME OF OFFICIAL COMPLETING FORM	SIGNATURE X	DATE SIGNED	SCHOOL/PARISH TELEPHONE NUMBER ( )

PART B VOLUNTEER'S INFORMATION

VOLUNTEER'S FULL NAME	MOBILE TELEPHONE NO. ( )	HOME TELEPHONE NO. ( )

ADDRESS	CITY	STATE	ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

ARE YOU COVERED UNDER ANY OTHER HEALTH AGREEMENT AND/OR ACCIDENT INSURANCE PLAN(S)? ☐ YES ☐ NO IF SO, NAME OF PLAN(S)	POLICY NUMBER(S)

NAME OF SPOUSE/DOMESTIC PARTNER	MOBILE TELEPHONE NO. ( )	HOME TELEPHONE NO. ( )

ADDRESS	CITY	STATE	ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed	WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER	CITY	STATE	ZIP CODE

I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment. *I hereby authorize any diocesan authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.*	VOLUNTEER'S SIGNATURE X DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF VOLUNTEER_____ DATE_____

CLAIM FILING PROCEDURE

1. Report volunteer-related injuries to school/parish officials within 72 hours.
2. PART A of this claim form must be completed by a school/parish official.
3. PART B of this claim form must be completed by you.
4. IMPORTANT: Both parts must be completed in full or claim will not be processed.
5. Mail, fax or scan/email form to Myers-Stevens & Toohey with all itemized bills **within 90 days of the first date of treatment.** Required itemized bills come in the form of a *UB04 Billing Form* for hospitals/facilities and a *CMS (HCFA) 1500 Billing Form* for all other providers. We are unable to process receipts of payment or statements in lieu of itemized bills.
6. If you are covered under any other health and/or accident plan(s), you must first file a claim with such plan(s). These can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plans or health maintenance organizations (HMO). When you receive a notice of payment, a notice of denial or a letter stating you have met your deductible from your other plan(s), please forward copies to our office in a timely fashion to expedite the processing of your claim.
7. If you are otherwise uninsured, your claim as submitted to us will be processed on a primary basis.
8. If you have any questions, please call (800) 827-4695 or email claims@myers-stevens.com

EXCESS PROVISION : These plans pay benefits on an excess or secondary basis. This means, if a person is covered by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount.

COMMONLY ASKED QUESTIONS

Q: Do I have to go to a specific doctor or hospital?

A: *No, you can go to the doctor or hospital of your choice.* However, if you go to a provider within the provider network, you may have your out-of-pocket expenses significantly reduced. To find a participating provider in your area, call 800-226-5116 or log on to www.myfirsthealth.com. In Washington or Idaho, call 800-823-6935 or log on to: www.fchn.com.*

Q: Do I need to attach a claim form for each bill?

A: *No, only one claim form is required per injury or sickness.*

**Important:* If you are covered by an HMO plan and seek treatment (other than emergency care) from providers not authorized by that plan, we will pay 50% of the amount for such charges that we would otherwise pay if you did not have such HMO coverage.

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Underwritten by:
ACE American Insurance Company

CHUBB®

First Health®

First Choice Health
PPO Network - ***WA, ID***

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

For residents of Oregon: WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material thereto, may be subject to prosecution for insurance fraud.

For residents of Washington WARNING: 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.