Policy Number: _____

ADMINISTRATIVE CONCEPTS, INC.

PARTICIPANT ACCIDENT INSURANCE CLAIM FORM

U.S.SOCCER DEVELOPMENT ACADEMY

(NOTE To the Participant/Parent/Guardian: Report and Claim Form will be returned if not fully completed and signed.)

Basic Procedures for Submitting the Incident Report and Participant Accident Insurance Claim Form

1. **The insurance coordinator, coach or league representative, official, trainer, promoter will complete the incident report (front). An event participant or parents of an event participant will complete the participant accident medical insurance claim form (Part II).**

2. **The participant or participant's parents/guardian will complete the form, detach it from the instruction page, and forward it to Melissa Biniewicz of U.S. Soccer.**

3. **This is an excess medical policy. Other insurance will apply first. Please follow pre-authorization requirements of your primary health care provider.**

4. **IF YOU DO NOT HAVE OTHER INSURANCE AND THE CLAIM IS NOT AN EMERGENCY BUT OF SERIOUS INJURY, PRE-AUTHORIZATION WITH ADMINISTRATIVE CONCEPTS, INC (ACI). IS REQUIRED FOR ANY TREATMENT OR SURGERY. CONTACT INFORMATION FOR ACI, INC. IS LISTED BELOW.**

To the Participant/Parent/Guardian:

Attach current itemized physician, hospital, or other provider's bills for accident medical expenses being claimed as well as the primary carrier's Explanation of Benefits showing their payments and denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made.

ACI – Administrative Concepts, Inc.

Claims Department - Participant Accident

994 Old Eagle School Road, Suite 1005

Wayne, PA 19087-1802

Phone: (610) 293-9229 • Fax: (610) 293-9299

ACI ADMINISTRATIVE CONCEPTS, INC.

U.S. SOCCER INCIDENT REPORT

U.S.SOCCER DEVELOPMENT ACADEMY

(PLEASE PRINT)

NATURE	❑ BODILY INJURY ❑ OTHER:
TIME & PLACE OF INCIDENT	DATE: TIME: ❑ A EVENT NAME: Development Academy Event M EVENT TYPE: SANCTIONED BY: U.S.Soccer LOCATION: CLUB NAME: CITY: STATE:
HAPPENED TO	NAME: SSN: DATE OF BIRTH: SEX: ❑ Male ❑ Female PHONE: ( ) ADDRESS: CITY: STATE: ZIP:
FUNCTION	AS: ❑ ATHLETE ❑ TRAINING CENTER ❑ COACH ❑ TRYOUT
APPARENT INJURY	BODY PART: CONDITION: (Laceration, Concussion, Sprain, Fracture, Etc.): ❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: ❑ AMBULANCE, TAKEN TO: CITY: ❑ FATALITY
OCCASION	❑ PRACTICE ❑ GAME
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:
INSURED	NAME OF INSURED: U.S. Soccer POLICY#:
INSURED REPRESENTATIVE U.S. Soccer	NAME: Melissa Biniewicz PHONE:( ) 312 528-1228 TITLE: Development Academy Operations Manager SIGNATURE: DATE:

COMPLETE ALL SECTIONS AND EMAIL OR FAX TO:
U.S. Soccer • Attention: Melissa Biniewicz
email: mbiniewicz@ussoccer.org • Fax: (312) 808-1301

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ADMINISTRATIVE CONCEPTS, INC.

ACCIDENT MEDICAL INSURANCE CLAIM FORM

U.S.SOCCER DEVELOPMENT ACADEMY

Policy Number: _____

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE FURNISHED. OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

TO BE COMPLETED BY INJURED PERSON OR PARENT

PART II

MEDICAL BENEFITS UNDER THIS POLICY PROVIDE EXCESS COVERAGE. PRIMARY HEALTH CARE INSURANCE WILL APPLY FIRST. PLEASE FOLLOW PRE-AUTHORIZATION REQUIREMENTS OF YOUR PRIMARY HEALTH CARE PROVIDER. IF YOU DO NOT HAVE PRIMARY HEALTH CARE INSURANCE AND THE CLAIM IS NOT AN EMERGENCY BUT OF SERIOUS INJURY, PRE-AUTHORIZATION ADMINISTRATIVE CONCEPTS, INC (ACI). IS REQUIRED FOR ANY TREATMENT OR SURGERY. PLEASE CONTACT ACI AT (610) 293-9229 OR FAX (610) 293-9299.

YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN OR YOUR PARENT'S PERSONAL HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL.

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. IT IS IMPERATIVE THAT WE RECEIVE ALL DATA REQUESTED. TIMELY RECEIPT OF REQUESTED INFORMATION WILL HELP EXPEDITE PROCESSING OF YOUR CLAIM.

MEDICAL PROVIDERS: IN ABSENCE OF AUTHORIZATION, SILENCE IS ACCEPTANCE OF AN OFFER OF PAYMENT OF 90% OF CMS MEDICARE PAYMENT POLICIES OF STATE OF FILING AND REDUCTION OF ALL COMPLEX AND VERY COMPLEX CPT CODES TO SIMPLE TO MODERATE CPT CODES.

INJURED PERSON:	SPOUSE'S NAME (if applicable):
FATHER'S NAME (if injured is a minor)	MOTHER'S NAME (if injured is a minor)
EMPLOYER NAME:	EMPLOYER NAME:
❑ UNEMPLOYED EMPLOYER ADDRESS:	EMPLOYER ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE: ( )	PHONE: ( )
GROUP INSURANCE COMPANY:	GROUP INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:
INSURANCE COMPANY ADDRESS:	INSURANCE COMPANY ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
SOCIAL SECURITY NUMBER:	SOCIAL SECURITY NUMBER:
SIGNATURE:	SIGNATURE:

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ACI OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO ACI OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: _____ DATE: _____

Please Note: If injured person is a minor, signature must be of parent or legal guardian.

Important Notice

- ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** 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.

- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.

- ***For residents of 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.

- ***For residents of the District of Columbia:*** *WARNING:* 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.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- ***For residents of Maine, Tennessee, Virginia and 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 include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** 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 may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland :*** Any person who knowingly or 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.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** 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 CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 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.

- ***For residents of Ohio:*** Any person who, 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.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, 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.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.