

Participant Accident Claim Form

For Office Use Only

Policy Number
Reference Number
Coverage Code

Complete both sides of this form. Attach bills and insurance payment records.

Mail to: **AGIA, Inc.**
P.O. Box 9851
Phoenix, AZ 85068-9851
Phone: 800-399-2560



**Beech Street Preferred
 Provider Network Plan**

Life Insurance Company of North America
 Insurance Company of North America
 CIGNA Life Insurance Company of New York
 Connecticut General Life Insurance Company



FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.
For residents of the following states, please see end of the form: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

CLAIM FORM INSTRUCTIONS

- **Part I** - Must be completed by group/organization official if accidental injury occurs during a sponsored or supervised activity. If accidental injury does not occur during a sponsored or supervised activity, Part I of claim form should be completed by the claimant - or by the parent or guardian if the claimant is a minor (under 18 years of age).
- **Part II** - Must be completed by the claimant or by the parent or guardian if the claimant is a minor.
- **Part III** - Must be completed by physician or dentist providing treatment or services.
- The claim must be submitted within 90 days from the date of injury or as soon as possible thereafter.
- Attach itemized bills showing diagnosis, treatment, dates of treatment, and charges with corresponding explanation of benefits statement to this claim form. Forward all additional bills with record of payment from your primary insurance.
- Please note the name of the school district on all bills and correspondence.
- All benefits will be made payable to the physicians and providers involved, unless accompanied by paid receipts.

PART I - GROUP/ORGANIZATION REPORT

1. Name of Group/Organization			2. Address				
3. Name of Insured	Last	First	Middle Initial	4. Social Security No.	5. Grade	6. Birthdate	7. Sex
8. Nature of Injury (Please describe, fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.)							
9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO ACCIDENT.							
10. Did Accident occur:		Yes	No	11. a) Date of Accident:		12. Name of Activity	
a) While claimant was group supervised?		<input type="checkbox"/>	<input type="checkbox"/>	b) Time:		13. Name/Title of Group Supervisor	
b) During group sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>	c) Place:			
c) During programmed hours?		<input type="checkbox"/>	<input type="checkbox"/>				
d) On activity premises?		<input type="checkbox"/>	<input type="checkbox"/>				
e) While traveling directly and uninterruptedly to or from home premises and group sponsored and supervised activities?		<input type="checkbox"/>	<input type="checkbox"/>				
f) Off group premises, at home, during the weekend, holiday, or summer vacation?		<input type="checkbox"/>	<input type="checkbox"/>				
14. Signature of Group/Organization Official				15. Title		16. Date	

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

PART II - TO BE COMPLETED BY CLAIMANT - OR BY PARENT IF CLAIMANT IS A MINOR

1. Claimant, if over age 18, or if a minor, Name of Father or Guardian		2. Claimant, if over age 18, or if a minor, Social Security No.	
3. Claimant, if over age 18, or if a minor, Name of Mother or Guardian		4. Claimant, if over age 18, or if a minor, Social Security No.	
5A. Claimant, if over age 18, or if a minor, Address of Parents or Guardian/or Claimant		5B. Claimant, if over age 18, or if a minor, Telephone Number	
6A. Claimant, if over age 18, or if a minor, Father or Guardian's Insurance Company		Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group	6B. Claimant, if over age 18, or if a minor, Mother or Guardian's Insurance Company
7A. Claimant, if over age 18, or if a minor, Name and Address of Father or Guardian's Employer		7B. Claimant, if over age 18, or if a minor, Name and Address of Mother or Guardian's Employer	
8. List other insurance policies under which claimant is insured:		Policy No.	<input type="checkbox"/> Individual <input type="checkbox"/> Group
a. Company:			
b. Other Insurance:		Policy No.	<input type="checkbox"/> Individual <input type="checkbox"/> Group
9. Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee, or dependent?			
a. Preferred Provider Organization (PPO) or similar health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy No. _____	
If yes, name of PPO or Organization _____			
b. Health Maintenance Organization (HMO) or similar prepaid health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy No. _____	
If yes, name of HMO or Organization _____			
10. If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:			
Name of Insurance Company _____		Policy No. _____	
Name of Policyholder _____			

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

Signature (Parent or guardian if claimant is a minor)	Date	Phone No.
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PAYMENT AUTHORIZATION - I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature (Parent or guardian if claimant is a minor)	Date
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PART III - TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

1. DIAGNOSIS OR NATURE OF INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR ICD-9 CODE. 1. 2. 3. 4.		2. DATE FIRST CONSULTED FOR THIS CONDITION	3. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED		
		4. NAME AND ADDRESS OF REFERRING PHYSICIAN			
5. A. DATE OF SERVICE	B. PLACE OF SERVICE ★	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (Identify:) (Explain unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES	
9. YOUR PATIENT'S ACCOUNT NUMBER		10. PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING TAX I.D. # _____ SOC. SEC. # _____		11. PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS 12. PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER ()	
				6. TOTAL CHARGE 7. AMOUNT PAID 8. BALANCE DUE	
I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.		13. PHYSICIAN'S OR PROVIDER'S SIGNATURE		14. DATE	
★ 1. (H) — Inpatient Hospital 2. (OH) — Outpatient Hospital		3. (O) — Doctor's office 4. (H) — Patient's Home		5. (PSY) — Day Care Facility 6. (SNF) — Night Care Facility	
		7. (NH) — Nursing Home 8. (SNF) — Skilled Nursing Facility		9. Ambulance O. (OL) — Other Locations	
				A. (IL) — Independent Laboratory B. Other Medical Facility	

TO BE COMPLETED BY ATTENDING DENTIST

1. DENTIST NAME				10. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES		
2. MAILING ADDRESS				11. IS TREATMENT RESULT OF AUTO ACCIDENT?						
3. CITY, STATE, ZIP				12. OTHER ACCIDENT?						
4. TAX I.D. # TO BE USED FOR TAX REPORTING		TAX I.D. #		SOC. SEC. #		13. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		IF YES, NAME OF OTHER PLAN:		
5. DENTIST LICENSE NO.			6. DENTIST PHONE NO.			14. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)		
7. FIRST VISIT DATE CURRENT SERIES		8. PLACE OF TREATMENT OFFICE · HOSP · ECF · OTHER		9. RADIOGRAPHS OR MODELS ENCLOSED? NO YES		HOW MANY?		15. IS TREATMENT FOR ORTHODONTICS?		
								IF SERVICES ALREADY DATE APPLIANCES MOS. TREATMENT COMMENCED, ENTER: PLACED REMAINING		
Indicate missing teeth with an "X"				17. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN						
				TOOTH # OR LETTER	SURFACE (i.e. M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)		DATE SERVICE COMPLETED MO DAY YR	PROCEDURE NUMBER (ADA CODES)	FEE
18. REMARKS FOR UNUSUAL SERVICES				19. SIGNED (DENTIST)		DATE		TOTAL FEE CHARGED \$		
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE				(Signature line)		(Date line)		(Total Fee Charged line)		

IMPORTANT CLAIM NOTICE

California & Texas Residents: Any person who knowingly presents a 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.

Colorado Residents: 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 Residents: 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.

Florida Residents: 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.

New York Residents: 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.

Tennessee Residents: 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.

Virginia Residents: Any person who, with the 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 may have violated state law.