



NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for **accident medical claims**. **Claims must be filed within 90 days of injury and contain a valid social security number and/or visa number before processing can begin.**

Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Deductible (\$200)

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Claim Form

This company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is sent.

- If the injured person has primary health insurance has the claim been submitted first to the primary?* _____
- If claim has first been submitted to the primary, are copies of the EOB's (explanation of benefits attached)?* _____
- Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* _____
- Is part (B) of the claim form completed by the injured person and signed?* _____
- Are the attached medical bills itemized in either a CMS 1500 or UB04 form?* _____
- Is part (B) , item number 3, (**social security number and/or visa number**) completed?* _____

Mailing the Claim

When completed in full, mail the attached completed form, itemized medical bills and copies of the EOB's (explanation of benefits, for use if coverage is excess) to:

The Loomis Company
AYSO Accident Claims
P O Box 13906
Reading, PA 19612-4085

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 410-1089.

Documents may also be faxed to the claims office at (610) 373-9707. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, Parts A & B of this claim form should be submitted WITHIN 90 days of the first day of the injury.

ACCIDENT DEDUCTIBLE CREDIT SHEET

Injured's Name: _____

Policyholder's Name: _____

Date of Injury: _____

Name & Address check should be sent to:

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

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NOTICE of Claim

WARNING: 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 may be guilty of a crime and may be subject to civil fines and criminal penalties. **California Residents:** For your protection California law requires the following to appear on this form: "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."

PART A – This part MUST be completed, dated and signed by an official of the organization.			
1. Name of Organization (Policyholder) American Youth Soccer Organization (AYSO)			
2. Policy Number: BAP-102264-1			
3. AYSO Region #			
4. AYSO Player/Volunteer ID #			
5. Name of Injured Person (Insured) (First) (Middle) (Last)			
6. Date of Accident/Injury Mo Day Year / / /	7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____		8. Type of Sport or Activity:
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.			
10. Describe the nature of injury			
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Name of Supervisor of Activity		13. Was he/she a witness Yes <input type="checkbox"/> No <input type="checkbox"/>
14. AYSO Regional Commissioner Signature X _____	15. Date signed	16. AYSO Safety Director Signature X _____	17. Date signed

