

**INSTRUCTIONS FOR FILING A
CLASS INSURANCE / SPORTS INSURANCE CLAIM**

INJURED PLAYER (PART I, II, III):

- Event, Activity, Sport
- Name / SS# / Gender / Date of Birth / Email
- Address / Phone Number
- Type of Injury
- Read the Fraud Warning on page 3
- Collect itemized medical bills for payment consideration, which would be forwarded to Administrative Concepts, Inc. If other insurance exists, include insurance company(s).
- Please retain a copy of the form for your own records.

SPORTS OFFICE (PART I):

- Date / Time / Place of Accident
- How/ Where Accident Occur
- Signature

SUBMIT CLAIM FORMS TO THE SCMAF OFFICE:

FAX:
(626) 448-5219

MAIL:
SCMAF CLAIMS
PO BOX 3605
SOUTH EL MONTE,
CA 91733

EMAIL:
SCMAF@SCMAF.org

SCMAF OFFICE:

SCMAF will **verify Part I** of the form and forward the information to **Administrative Concepts Inc.**

HELPFUL INFORMATION:

- List Administrative Concepts, Inc. to your provider as secondary insurance.
- A fully completed claim form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called “ub-04” for hospital charges and/or a “cms-1500” for physician charges).
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

ANY QUESTIONS REGARDING CLAIM FORM: SCMAF (626) 448-0853 ext. 11
ANY QUESTIONS REGARDING PENDING CLAIM: ACI: (888) 293-9229

1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
 3. MAIL TO
 Administrative Concepts, Inc
 994 Old Eagle School Road
 Suite 1005
 Wayne, PA 19087-1082
 www.visit-aci.com



PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number: SRPO-50256-243		Organization Name: Southern California Municipal Athletic Federation		Event, Activity or Sport:	
Claimant's Name (Injured Person)		Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	E-Mail Address
Address of Injured Person and Best Contact Phone Number (Include Area Code)					
Date and Time of Accident		Place where Accident Occurred		The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other	
Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Describe How Accident Occurred – Provide All Possible Details			Activity Where the Accident Occurred: <ul style="list-style-type: none"> • Day Camp <input type="checkbox"/> • Overnight Camp <input type="checkbox"/> • League Game or Practice <input type="checkbox"/> • Tournament <input type="checkbox"/> • Other _____ <input type="checkbox"/> 		

Did Accident Occur (Check Yes or No for Each of the Following):

- | | | |
|--|------------------------------|-----------------------------|
| A. On activity premises? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| B. While traveling directly and uninterruptedly to or from the activity? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| C. During a participating organization practice? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| D. During a participating organization competition? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| E. During an activity sponsored by the participating Organization? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date
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PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? YES NO

If Yes, name of insurance company:: _____ Policy #: _____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

YES NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ **DATE** _____

Fraud Statements

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 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 Maryland and 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 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.