



2006
USA Track & Field
MEDICAL CLAIM FORM

Send this form to:
 Loomis Benefits West
 PO Box 13814
 Reading, PA 19612
 (888) 585-7065

This form to be completed whenever a medical claim results from an injury incurred at USA Track & Field sanctioned event.
 PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY							
NAME (Last Name) (First Name) (Middle Initial)			SOCIAL SECURITY NUMBER		DATE OF BIRTH		SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS (Street) (City) (State) (Zip Code)				TELEPHONE NUMBER ()		OCCUPATION	
USA Track & Field MEMBERSHIP #:			DATE & TIME OF ACCIDENT: ____/____/____ ____ AM ____ PM				
INJURED PARTY WAS: <input type="checkbox"/> PARTICIPANT <input type="checkbox"/> COACH <input type="checkbox"/> OFFICIAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER: _____							
CLUB or ASSOCIATION NAME:			COACHES NAME:		PHONE #: ()		
NATURE OF INJURY							
FOR ALL INJURIES, PLEASE COMPLETE THE FOLLOWING:							
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT: _____ _____							
B. DESCRIBE WHERE ACCIDENT HAPPENED: _____ _____							
C. DESCRIBE HOW ACCIDENT HAPPENED: _____ _____							
D. DID THE ACCIDENT OCCUR DURING: <input type="checkbox"/> SANCTIONED COMPETITION <input type="checkbox"/> REGISTERED CLUB PRACTICE <input type="checkbox"/> TRAVELING TO/FROM <input type="checkbox"/> OTHER: _____							
E. WITNESS NAME: _____ PHONE #: _____							
IF INJURED PARTY IS A MINOR: PARENT/GUARDIAN NAME: _____ HOME PHONE #: _____ EMPLOYER NAME: _____ WORK PHONE #: _____							
IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS, INCLUDING BUT NOT LIMITED TO GROUP OR INDIVIDUAL MEDICAL, MILITARY/GOVERNMENT PLANS SUCH AS MEDICARE, OR AUTOMOBILE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF YES, NAME OF INSURANCE COMPANY					POLICY NUMBER		
ADDRESS (Street) (City) (State) (Zip Code)							
AUTHORIZATION TO RELEASE INFORMATION							
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information, to The Loomis Company, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photo static copy of the original shall be valid for the duration of the claim.							
NAME OF PATIENT			SIGNATURE OF PATIENT (PARENT/GUARDIAN IF A MINOR)			DATE	
AUTHORIZATION TO PAY PROVIDER - I authorize payment associated with this incident directly to the physicians or providers.			IF YES, SIGNATURE			DATE	
I certify that the foregoing information is true and correct.			SIGNATURE			DATE	

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.



2006
USA Track & Field
MEDICAL CLAIM FILING INSTRUCTIONS

1. **DO NOT MAIL CLAIM FORMS, BILLS OR OTHER ITEMS TO USA TRACK & FIELD.**
2. Complete claim form in full. Use an additional sheet if necessary.
3. Attach current itemized physician, hospital or other providers' standard insurance billing forms: HCFA from physician or UB 92 from Hospital. These forms must show the following:
 - Patients Name
 - Condition/Diagnosis
 - Type of Treatment
 - Date expense incurred
 - Charges
4. Your coverage is an excess policy unless there is no other insurance in place. **This policy has a \$200 deductible. Other policy information can be found at www.usatf.org/membership/benefits/.** Attach your primary insurance carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have, including employer insurance (spouse, parent or guardian), Medicare, Medicaid, Armed Forces or other coverage.
5. To expedite proper processing, submit form complete in full along with the above documents to the following address:

Loomis Benefits West
PO Box 13814
Reading, PA 19612
(888) 585-7065

Important Claim Notice

California Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

District of Columbia & Pennsylvania 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 subjects such person to criminal and civil penalties.

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.

Kentucky Residents: 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 any fact material thereto commits a fraudulent insurance act, which is a crime.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

Ohio Residents: 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.

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.

For All States Other Than Those Above: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. This notice does not apply in Virginia.