CLAIM INSTRUCTIONS

AYSO Soccer Accident Insurance (SAI)

insuring progress®

These Instructions are to be used for completing the **SAI CLAIM FORM** for injuries STARTING July 1, 2012!

*****Note: The claim form AS FOLLOWS should be submitted to Administrative Concepts, Inc. ("ACI") – address below – as soon as possible after medical treatment has been administered for an injury and not later than 90 days after injury date. Submit the claim form to ACI to ensure notification is received timely. Once the primary carrier has paid send a copy of the itemized bill and primary carrier EOB to ACI for additional benefit consideration Keep copies of everything sent to ACI.***

Policies with 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.

Claim Form

The claim form must be submitted for each individual claim. **Section A** 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. **Section B** must be completed in full and signed by the AYSO Officials – **Regional Commissioner and Safety Director!** ***A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.***

Deductible ($200)

Each claim is subject to the $200 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.

Medical Bills

Notify all medical providers – hospitals and doctors – if you will be using this insurance. Provide them with the name and mailing address to ACI (provided below) when requesting they submit the required insurance billing forms. A physician's office should submit a CMS 1500. A hospital and/or emergency room should submit a UB04. **A balance due statement is not acceptable and will only delay processing.**

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US Mail. Please forward the requested information immediately to ACI, so that they may finish adjudicating your claim in a swift manner.

Claim Submission Checklist – *FOR INJURIES THAT OCCURRED BETWEEN JULY 1, 2012 and JUNE 30, 2013.*

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

If the injured person has primary health insurance has the claim been submitted first to the primary?	
If claim was first submitted to the primary, are copies of the EOB's (explanation of benefits) ***if available***, attached?	
Have you requested itemized medical bills - CMS1500 or UB04 - to be ***sent directly to ACI?*** • ***Address: ACI, 994 Old Eagle School Road, Suite 1005, Wayne, PA 19087-1802***	
Has Part B been completed and signed by the AYSO Regional Commissioner and Safety Director?	
I have reviewed the SAI benefits as described at http://www.ayso.org/resources/insurance.aspx.	
Claim forms are **NOT** being submitted prior to MEDICAL SERVICES being incurred.	

Mailing the Claim

When completed, **claimant (or parent/guardian)** should make copies of all documents and mail the claim form including itemized medical bills *(if not mailed directly to ACI by the medical providers)* and copies of EOB's *(explanation of benefits from primary insurance)* to:

- **Administrative Concepts, Inc., 994 Old Eagle School Road Suite 1005, Wayne, PA 19087-1802**
- *(**Tip**: We recommend mailing everything Certified/Return Receipt and to keep copies of all documents)*

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 888-293-9229.

Basic Plan Details: *$200 deductible applies to each claim; social security number is required; must be filed within 90 days; $1000 limit on physical therapy.*

AYSO ACCIDENT CLAIM FORM – YOUTH PROGRAM

MAIL TO:
Administrative Concepts,Inc.
994 Old Eagle School RoadSuite1005
Wayne, PA 19087-1802
Phone:888-293-9229
www.visit-aci.com

Any person who knowingly presents a false or fraudulent claim for payment of 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.

PART A-This PART **MUST** be **completed**,**dated** and **signed** by the Injured Person - or if the Injured Person is under age 18 or otherwise dependent - by his/her Parent or Guardian.

1. Name of Organization (Policyholder)	2. Policy No.
American Youth Soccer Organization (AYSO) Youth Program	**PTP N04836510**

3. Address of Organization (Street)	(City)	(State)	(Zip)
19750 S Vermont Ave Ste. 200	**Torrance**	**CA**	**90502**

4. Name of Injured Person (Insured) (First) (Middle) (Last)

PRINT HERE - NAME OF PERSON COMPLETING FORM: Check one: Injured Person ☐ Parent ☐ Guardian ☐

Give the following information about the Injured Person:

5. Date of Birth Mo. Day Year / /	6. Male ☐ Female ☐	7. Social Security No. / /	8. Area Code/Telephone No. ( )

9. Address (Street) (City) (State) (Zip)

10. Employer (Name) Address: (Street) (City) (State) (Zip)

Area Code / Employer Telephone No: ( )

11. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ☐ No ☐ If YES, Give the following information:

Name of other Insurance Company(s) Address of other Insurance Company(s) Policy Number(s) Name of Policyholder(s)

12. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian Place of Employment Area Code/Employer Phone No.

Name of Mother or Female Guardian Place of Employment Area Code/Employer Phone No.

13. If the Injured Person is married, give the following information:

Name of Spouse Place of Employment Area Code/Employer Phone No.

14. Explain HOW the accident and injury occurred and describe the nature of the injury. NOTE: If your organization uses an Incident Report Form, attach a copy of the Report. _____

PART B - This PART **MUST** be completed by an AYSO Official

1. Date of Accident/Injury Mo. Day Year / /	**2. Injury Occurred:** Practice ☐ Travel ☐ Game ☐ Other _____	**3. AYSO Region No.**	**4. AYSO Player/Volunteer ID No.**
5. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐		6. Name of Supervisor of Activity	7. Was he/she a witness to the accident?

8. Signature of Regional Commissioner	**9. Date Signed**	**10. Signature of Safety Director**	**11. Date Signed**
✕ _____	/ /	✕ _____	/ /

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or theunderwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determineif my claim ia eligible. Any information obtained will not be released by the Company in connection with my claim. Acopy of this authorization shall be considered as effective and valid as the original and shallremain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct. I understand that the intentional furnishing of incorrectinformation via the US Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I willreimburse Administrative Concepts, Inc. to the extent for which Administrative Concepts, Inc. would not have been liable.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____
STREET CITY STATE / ZIP