

Insurance Company of the State of Pennsylvania

American International Companies®

COVERAGE VERIFIED

MAIL TO:
Macori Administration
 P. O. Box 2567
 Spring, TX 77383-2567
1-800-285-8133

CLAIM FORM

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

SPECIAL NOTICE: 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 may be guilty of a criminal act punishable under law.

**- PLEASE PRINT ALL INFORMATION -
 MUST BE COMPLETED AND SIGNED**

Name of School			Group Number	Birth Date
Insured's Name			Insured's Social Security Number	Telephone Number
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>		
Present Address				
<i>No. and Street</i>	<i>City or Town</i>	<i>State</i>	<i>Zip + 4</i>	
Home Address				
<i>No. and Street</i>	<i>City or Town</i>	<i>State</i>	<i>Zip + 4</i>	

If claim for dependent, give dependent's name: _____ Relationship to insured: _____ Date of Birth: _____

MUST BE COMPLETED	Are you covered (as an insured or dependent) by any other hospital and/or medical plan? <input type="checkbox"/> Yes Insured <input type="checkbox"/> Yes Dependent <input type="checkbox"/> No			
	If yes, please check one: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Automobile/Medical			
	If yes, also indicate name and policy number of Insurance Company.			
	Name of Insured:	Policy#/Group#:	I.D. #	Company
	Have you filed a claim with the above company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.			
Name and address of Employer of:				
<input type="checkbox"/> Insured, if employed _____				
<input type="checkbox"/> Spouse, if insured is married _____				

1. Date of accident or sickness.	Date of first treatment.
2. Nature of sickness or injury.	
3. If injury, describe how and when accident occurred and indicate if work related.	
4. *If injured in play or practice of sport, indicate which sport.	Check one: <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other
5. Have you previously been troubled with this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
6. Give names of all other physicians consulted.	
7. Hospitalized? If so, where and what dates.	Where: _____ From: _____ To: _____
8. Health Center Referral?	<input type="checkbox"/> Yes If yes, attach referral to claim form. <input type="checkbox"/> No If no, please explain.

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician, and others), UNLESS A PAID RECEIPT OR PAID STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

***IMPORTANT - ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL.**

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision. _____ DATE

***Signature of College Official** _____ **Title** _____ **Date** _____

To any medical care provider, medical care facility, insurer, government-sponsored health plan or employer: I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. 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 find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

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

If Authorized Representative, Relationship to Patient _____

STREET CITY STATE ZIP + 4