AIG

WebTPA
An AmWINS Group Company

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number: AH-GA26932-13	Policyholder / Organization Name: Ganado ISD		Event, Activity or Sport:	
Name of School: Ganado ISD	Street Address 210 South 6th Street	City Ganado	State TX	Zip Code 77962
Claimant's Name (Injured Person)	Social Security Number	Gender ☐M ☐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: ☐ Participant ☐ Staff Member ☐ Other

Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) | Did Injury Result in Death? ☐YES ☐NO

Describe How Accident Occurred – Provide All Possible Details

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

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐YES ☐NO
B. On activity premises? ☐YES ☐NO
C. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
D. During a participating organization practice? ☐YES ☐NO or competition? ☐YES ☐NO

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date

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 **National Union Fire Insurance Copmany of Pittsburgh, PA** 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 ***National Union Fire Insurance Copmany of Pittsburgh, PA*** 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** _____

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WebTPA

How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

WebTPA
P.O. Box 669
Grapevine, TX 76099-0669
Customer Service: (877) 563-7492
Fax: (469) 417-1989

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

The Participating Organization (not the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

HOW TO FILE A CLAIM

All information must be provided for a claim to be processed.

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer all questions and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to address below:

   WebTPA
   P.O. Box 669
   Grapevine, Texas 76099-0669
   Customer Service: 877-563-7492
   Fax: 469-417-1989

4. Advise all doctors / hospitals of this coverage so they may forward their itemized bills.
5. If you have already been to doctor / hospital and did not know about this coverage, send all itemized bills to address above.
6. Itemized bills should include name of doctor / hospital, complete mailing address, telephone number, date seen, what you were seen for (diagnosis) and specific itemized charges incurred. (Description of treatment including CPT codes and amount).
7. If you have other insurance, submit a claim to your other insurer. When an Explanation of Benefits is received from Primary Carrier, mail to address above along with all corresponding itemized bills and completed claim form. You must submit itemized bills which include:
   a) HCFA-1500 (standard form used by Providers)
   b) UB-04 or UB-92 (standard form used by Hospitals)
8. If you already paid the bill, include a paid receipt or copy of your cancelled check. Payment will be made to the Provider of Service unless a paid receipt statement accompanies the bill when claim form is submitted.
9. **Common Causes For Delays in Processing Claims**
   a) Claim Form not fully completed or not submitted.
   b) Balance Due, Balance Forward or Past Due statements submitted as itemized bills.
   c) Explanation of Benefits from Primary Carrier not provided with itemized bills.

Keep Copies of All Correspondence For Your Own Records Until Claim Has Been Processed.