

National Union Fire Insurance Co. of Pittsburgh, Pa

- Medical Claim Form
- 1. Complete this form
- 2. Attach all Bills
- 3. Mail To \_\_\_\_\_



**CLAIM ASSISTANCE:**  
**1-800-427-9308**

**P.O. BOX 6540 • HARRISBURG, PA 17112**  
ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS

INSTRUCTIONS AND PROCEDURE FOR FILING A CLAIM

<p><b>I. Complete the "Student Statement" part of the claim form</b></p> <ul style="list-style-type: none"> <li>A. Make sure you identify your college or university.</li> <li>B. It is important to know when, how and where your accident or illness began.</li> <li>C. Questions regarding other coverage you or your dependants are eligible for must be answered.</li> <li>D. Patient or parent (if patient is a minor) must always sign the Authorization to Release Information section.</li> </ul> <p><b>II. Make a final check to see that all parts of the claim form are complete.</b></p> <p><b>III. If you have other coverage make sure you attach all payment statements or denial letters.</b></p> <p><b>IV. Attach all medical bills relating to the claim</b></p> <ul style="list-style-type: none"> <li>A. Make sure all bills identify patient.</li> <li>B. All bills should show date of treatment, type of service, and amount of charges.</li> </ul> <p style="text-align: center;"><b>PAYMENT WILL BE MADE TO THE SOURCE OF SERVICES (HOSPITAL, PHYSICIAN, ETC.) UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED</b></p>
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STUDENT STATEMENT

STUDENT NAME		SOCIAL SECURITY NUMBER		NAME OF COLLEGE/UNIVERSITY	
ADDRESS		CITY	STATE	ZIP	TELEPHONE <small>School Home</small>
PATIENT (IF OTHER THAN STUDENT)		MALE <input type="checkbox"/>	PATIENT RELATIONSHIP TO STUDENT		PATIENT BIRTH DATE
		FEMALE <input type="checkbox"/>			
DATE ACCIDENT OR SICKNESS BEGAN	NATURE OF SICKNESS OR INJURY			DID ACCIDENT HAPPEN AT SCHOOL?	

IF AN INTERCOLLEGIATE SPORTS ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT  
**I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.**

SIGNATURE:	TITLE:	DATE:
NAME OF SPORT	TYPE OF SPORT	PART OF BODY INJURED
<input type="checkbox"/> CLUB <input type="checkbox"/> INTRAMURAL <input type="checkbox"/> INTERCOLLEGIATE		

GIVE NAME, ADDRESS AND TELEPHONE NUMBER OF PHYSICIAN

HAVE YOU BEEN TREATED BEFORE FOR SAME CONDITION?

YES  NO IF YES, when \_\_\_\_\_ By whom \_\_\_\_\_

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THESE EXPENSES OF THIS CLAIM?  YES  NO

NAME OF COMPANY			
FATHER'S NAME	FATHERS EMPLOYER	NAME	ADDRESS
MOTHER'S NAME	MOTHER'S EMPLOYER	NAME	ADDRESS
SPOUSE'S NAME	SPOUSE'S EMPLOYER	NAME	ADDRESS

**California:** For your protection, California law requires the following to appear on this form: 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 residents of New York:** 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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania:** 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 and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania:** 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.

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Company or Administrator. A photo static copy of this authorization shall be valid as the original.

**X** \_\_\_\_\_  
SIGNATURE OF INSURED OR PARENT (IF MINOR) DATE