



# NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for **accident medical claims**. **Claims must be filed within 90 days of injury and contain a valid social security number and/or visa number before processing can begin.**

### 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. Parts A & B of this form must be filed **WITHIN** 90 days of injury and may be filed prior to receiving all Primary Explanation of Benefits (EOBs) and itemized medical bills. After the primary insurance has paid benefits, you must submit copies of the EOBs to Loomis as you receive them from the primary insurance. Only then will this insurance begin adjudication and pay benefits if available.

### Deductible (\$200)

Each claim is subject to the \$200 deductible. If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the Accident Deductible Credit Sheet. This will ensure we will be able to credit the appropriate charges to the 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.

### Claim Form

This company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder (AYSO) official or a staff member and signed by the Regional Commissioner and Safety Director. Part (B) 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. **Note: A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident or /injury.**

### Medical Bills

Attach all medical bills, if you have received them. All submitted medical bills must be itemized for service. **A balance due statement is not acceptable and will only delay processing.** A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital. Notify all medical providers – hospitals and doctors – that you will be using this insurance. You may provide them with the name and mailing address to Loomis (provided on next page) requesting they submit the required billing forms.

### Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

### Claim Submission Checklist

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

- If the injured person has primary health insurance has the claim been submitted first to the primary?* \_\_\_\_\_
- If claim has first been submitted to the primary, are copies of the EOB's (explanation of benefits) if available, attached?* \_\_\_\_\_
- Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* \_\_\_\_\_
- Is part (B) of the claim form completed by the injured person and signed?* \_\_\_\_\_
- Are the attached medical bills itemized in either a CMS 1500 or UB04 form?* \_\_\_\_\_
- Is part (B) , item number 3, (social security number and/or visa number) completed?* \_\_\_\_\_

**Mailing the Claim**

When completed in full, mail the attached completed form, itemized medical bills and copies of the EOB's (if required) to:

The Loomis Company  
AYSO Accident Claims  
P O Box 13906  
Reading, PA 19612-4085

*(Tip: Recommend mailing everything Certified/Return Receipt)*

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 (866) 410-1089.

Documents may also be faxed to the claims office at (610) 373-9707. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

**PLEASE NOTE:** Parts A & B of this form must be filed **WITHIN** 90 days of injury and may be filed prior to receiving all Primary EOBs and itemized medical bills. **Please refer to the instructions on the previous page.**

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## ACCIDENT DEDUCTIBLE CREDIT SHEET

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*If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your request, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.*

Injured's Name: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Name & Address check should be sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____



# NOTICE of Claim

**WARNING:** 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 may be guilty of a crime and may be subject to civil fines and criminal penalties. **California Residents:** For your protection California law requires the following to appear on this form: "Any person who knowingly presents 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."

<b>PART A – This part MUST be completed, dated and signed by an official of the organization.</b>			
1. Name of Organization (Policyholder) <b>American Youth Soccer Organization (AYSO)</b>			
2. Policy Number: <b>BAP-102264-1</b>			
3. <b>AYSO Region #</b>			
4. <b>AYSO Player/Volunteer ID #</b>			
5. Name of Injured Person (Insured) (First) (Middle) (Last)			
6. Date of Accident/Injury Mo    Day    Year /       /		7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____	8. Type of Sport or Activity:
9. Explain <b>HOW</b> the accident and/or injury occurred. <b>NOTE:</b> If your organization uses an Incident Report form, attach a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		12. Name of Supervisor of Activity	13. Was he/she a witness Yes <input type="checkbox"/> No <input type="checkbox"/>
14. AYSO Regional Commissioner Signature  X _____		15. Date signed	16. AYSO Safety Director Signature  X _____
			17. Date signed

**PART B** - 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.

<b>PRINT HERE:</b> Name of person completing form:	<b>Check One:</b>	<input type="checkbox"/> Injured Person <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
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**AMERICAN YOUTH SOCCER ORGANIZATION** **Policy Number: BAP-102264-1**

**Give the following information about the Injured Person:**

<b>1. Date of Birth</b> Mo    Day    Year /    /    /	<b>2. Gender</b> ? Male ? Female	<b>3. Social Security # or Student Visa #</b> SS#    /    / visa#	<b>4. Area Code/Phone #</b> (    )
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**5. Address** (Street) (City) (State) (Zip)

**6. Employer** (Street) (City) (State) (Zip)

Employer Phone # (    )

**7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ? No ?**

If **YES**, provide the following information: Name of Policyholder(s):

Name of Other Insurance Company: Address: Policy #:

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

Name of Father or Male Guardian: Social Security #:  
/    /    /

Place of Employment: Address: Employer Phone #:  
(    )

Name of Mother or Female Guardian: Social Security #:  
/    /    /

Place of Employment: Address: Employer Phone #:  
(    )

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

Name of Spouse: Social Security #:  
/    /    /

Place of Employment: Address: Employer Phone #:  
(    )

I hereby authorize my physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Starr Indemnity and Liability Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

Injured Person  
**Check One:**  Parent  
 Guardian

**X** \_\_\_\_\_  
Signature (in writing) of Responsible Party

Date: \_\_\_\_\_

\_\_\_\_\_ Print Name