Catlin Insurance Company, Inc.

Dental Accident Claim Form

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

CLAIMANT'S STATEMENT

Claimant's Name_____**Date of Birth** ___/____/____ **Sex:** □ **M** □ **F**

Claimant's Address _____
(Street) (City) (State) (Zip)

Parent/Guardian Name _____ **Best Contact Phone No.:** ( ) _____

Name/City/State of school _____

Policy Number _____

CLAIM INFORMATION

Date and Time of accident _____/_____/_____ _____ □ AM □ PM

Please describe the location (playground, gym, etc.) and circumstances of accident (attach separate sheet if needed):

_____

_____

_____

_____

Below information Must be completed by School Official

Printed Name of School/Camp Official:_____**Title:**_____

School/Camp Official's Signature:_____**Phone #:**_____

WE MUST RECEIVE EMERGENCY ROOM OR OTHER FIRST TREATMENT NOTE (URGENT CARE, DOCTOR'S OFFICE) AND ANY OTHER MEDICAL RECORDS TO DEMONSTRATE CARE AND TREATMENT OF ACCIDENT RELATED INJURIES.

FILING INSTRUCTIONS

- **THIS CLAIM FORM MUST BE RECEIVED WITHIN 90 DAYS OF THE DATE OF ACCIDENT.**
- **THE RESPONSIBLE PARENT/GUARDIAN SHOULD COMPLETE THIS PAGE IN FULL.**
- **THE ATTENDING DENTIST SHOULD COMPLETE THE ATTACHED DENTIST'S STATEMENT. THE DENTIST MAY SUBMIT THE FORM DIRECTLY TO OUR OFFICE, OR YOU MAY RETURN IT WITH THIS CLAIM FORM AND OTHER DOCUMENTS.**
- **WE MUST RECEIVE ITEMIZED BILLS. WE CANNOT CONSIDER BALANCE DUE STATEMENTS WHICH ARE TYPICALLY NOT ITEMIZED. YOUR PROVIDER MAY FILE DIRECTLY ON YOUR BEHALF.**
- **MAKE COPIES OF THE AUTHORIZATION TO RELEASE INFORMATION FORM BEFORE COMPLETING THE PROVIDER SECTION IF YOU PLAN TO HAVE DOCUMENTS FROM MORE THAN ONE PROVIDER SUBMITTED FOR CONSIDERATION OF THIS CLAIM. PLEASE CALL US IF YOU NEED ADDITIONAL FORMS. GIVE THE AUTHORIZATION FORM TO ANY PROVIDER WHOSE RECORDS YOU WOULD LIKE TO SUBMIT WITH YOUR CLAIM (IF APPLICABLE).***

RETURN ALL DOCUMENTS TO:
Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087

TOLL FREE CUSTOMER SERVICE (888) 293-9229
Fax: (610) 293-9299
Email: aciclaims@visit-aci.com

ASSIGNMENT OF BENEFITS / CLAIMANT SIGNATURE

I certify that the information provided above is true and that the circumstances of the accident are as described herein. I acknowledge receipt of the attached Fraud Warnings Disclosure, and I understand that the submission of information for the purpose of defrauding an insurance company may be subject to criminal investigation and or penalties.

_____ _____

Signature of Parent/Guardian/Responsible Party **Date**

I assign payment of benefits directly to the service provider(s) associated with this loss and who provide standardized billing forms which include service itemization, coding, billing address and business tax identification number (TID) for tax purposes.

_____ _____

Signature of Parent/Guardian/Responsible Party **Date**

Catlin Insurance Company, Inc.

Dental Accident

ATTENDING DENTIST'S STATEMENT

DENTISTS PLEASE NOTE: THIS IS A LIMITED POLICY. YOU MAY NOT RECEIVE PAYMENT IN FULL FOR SERVICES RENDERED. BALANCES AFTER BENEFIT DISTRIBUTION ARE THE RESPONSIBILITY OF THE PATIENT.

IN ORDER TO BE PAID DIRECTLY, YOU MUST SUBMIT THIS QUESTIONAIRRE ALONG WITH STANDARDIZED BILLING FORMS WHICH CONTAIN ALL APPROPRIATE CODING, CHARGES, YOUR BILLING ADDRESS AND TAX IDENTIFICATION NUMBER.

PATIENT'S NAME:	REPORTED DATE OF INJURY:
DESCRIBE THE EXACT NATURE OF THE INJURY:	
DATE YOU FIRST TREATED THE PATIENT FOR THIS COMPLAINT:	_____ / _____ / _____
WERE THE EFFECTS OF THE INJURY IMMEDIATELY APPARENT? □ YES □ NO	IF NOT, WHEN DID THEY BECOME APPARENT?
HAVE YOU EVER TREATED THE PATIENT FOR A SIMILAR CONDITION? □ YES □ NO	IF YES, WHEN? PLEASE EXPLAIN:
HAS THE PATIENT FULLY RECOVERED FROM THIS SPECIFIC INJURY? □ YES □ NO	IF NOT, WHAT FURTHER TREATMENT DO YOU EXPECT TO PROVIDE?
IN YOUR PROFESSIONAL OPINION, WAS THIS CONDITION CAUSED SOLELY AND INDEPENDENTLY BY ACCIDENTAL INJURY? □ YES □ NO	IF NOT, PLEASE EXPLAIN ANY UNDERLYING MEDICAL CONDITION OR OTHER CAUSE YOU BELIEVE MAY HAVE CONTRIBUTED:
DESCRIBE THE CONDITION OF THE TOOTH PRIOR TO INJURY: □ SOUND/NATURAL □ FILLED □ CAPPED □ ARTIFICIAL □ OTHER _____	

Dentist must sign here:	Degree:		
Address:	City:	State:	Zip:
Date:	Tax Identification Number:		

TO EXPEDITE PROCESSING, YOU MAY RETURN THIS QUESTIONAIRRE, ALONG WITH YOUR VISIT NOTES AND STANDARDIZED BILLING FORMS, DIRECTLY TO THE CLAIMS ADMINISTRATOR AT:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087
TOLL FREE CUSTOMER SERVICE (888) 293-9229
FAX (610) 293-9299
EMAIL: aciclaims@visit-aci.com

Catlin Insurance Company, Inc.

RELEASE OF INFORMATION

Authorization Form

INSURED INFORMATION

Insured's Name_____ Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female

Insured's Address _____

Policy Number _____ Phone Number _____Social Security Number _____

I hereby authorize _____

(TREATING FACILITY/ PHYSICIAN/OTHER HEALTHCARE PROVIDER NAME HERE)

and its affiliates, employees and agents to release health information which identifies diagnosis, treatment, claims payment and healthcare services already provided or to be provided to:

_____ for _____

(Patient's full name) (dates of treatment)

Information should be released or mailed to: ☐ Individual ☐ Physician ☐ Institution ☑ Insurance Administrator

Administrative Concepts, Inc. **994 Old Eagle School Road, Suite 1005** **Wayne, PA 19087**	**Purpose:** **☑ Claims Payment ☐ Litigation** **☐ Medical Review ☐ Other:_____**

I request only the following information be released:

☐ ENTIRE MEDICAL RECORD	☐ Lab reports	☐ Operative Report	☐ X-Ray Report
☐ Emergency Room Report	☐ Pathology Report	☐ EKG	☐ X-Ray Film
☐ Admission History & Physical		☐ Cardiac Cath Lab Reports	☐ Itemized Billing Statement
☐ Discharge Summary		☐ Other _____	

I understand this release includes personally identifiable information such as name, address, social security number and insurance identification number. I also understand that this information may be subject to re-release by this entity for the purpose of resolving insurance benefit coverage determinations. As such, this information may no longer be protected by applicable state and/or federal privacy laws.

This authorization shall be valid for one year (365 days) from the date of my signature below or until _____.

(insert date)

I have the right to revoke this authorization by providing written notice to the receiving entity listed above. However, this authorization may not be revocable if the entity, its employees or agents have already acted on this authorization prior to receiving my written revocation. I understand that this authorization is voluntary, and that I have a right to a copy of this authorization. Refusal to sign this authorization does not affect my eligibility for enrollment or payment of covered services.

Member Signature: _____ **Date**: _____

(If other than member, please sign below and include a copy of written proof of legal authorization to represent the member or his or her estate (i.e. Power of Attorney, Guardianship, Executor, other)

Name of Legal Representative, if applicable: _____

Signature of Legal Representative: _____ Date: _____

Name of Witness, if signed by Representative: _____

Signature of Witness, if signed by Representative: _____ Date: _____

NOTICE TO POLICYHOLDERS

FRAUD NOTICE

Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	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.
California	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.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia	**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.
Indiana	Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	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 commits a fraudulent insurance act, which is a crime.
Louisiana	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.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 CIVIL FINES AND CRIMINAL PENALTIES.
New York	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.
Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	**WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.
Puerto Rico	**Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.**
Rhode Island	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.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NAIC Model	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.