

IMPORTANT !!!

Please Read Entire Claim Submission Form

NO CLAIM WILL BE PROCESSED UNLESS BOTH PART "A" AND "B" ARE SUBMITTED TO THE CAMP TEAM TOGETHER

Claim forms must be completely filled out and received within 90 day after the Date of Injury or the claim will not be processed.

A Deductible Will Apply To Each Claim.

Before sending in an Accident Claim Form, please make sure you (**THE POLICY HOLDER**) have the injured person/guardian completely fill out, sign, and date "PART B". The **POLICY HOLDER** completely fills out, sign, and date "PART A". Please fax a copy and mail the original to:

**The Camp Team
7615 W. 38th Ave., Suite B-109
Wheat Ridge, CO 80033
Attn: Claims Division
Fax 303-422-1276**

For an explanation on claims processing procedures, refer to the attached form "**NOTIFICATION OF INJURY FORM**". Please use Claim submission checklist as a guide.

Policy Holder:

Do not answer question #2 on "Part A" of the CLAIM FORM . Our office will order a medical policy number, once we are notified of an injury.

Injured Person/Guardian:

If all Explanation of Benefits (EOB's), medical itemized billing, HCFA 1500 and/or UB92 are not available before submitting the claim form "**Do Not Worry!**" There is a 52 week period to get all claims processed.

After the Initial claim submission to The Camp Team

The claim will be processed by our office and submitted to the Insurance Carrier where a claims adjuster will begin processing the claim. After the initial claim submission, all payment questions should be directed to the Insurance Carrier. Please contact The Camp Team after the claim has been submitted for more assistance. Include following information, 1) Injured Persons Name 2) Name of policy holder 3) Date of Injury 4) When was the Claim Submitted.

Should you have any questions regarding claims process or initial submission, please contact our office 800-747-9573.

NOTIFICATION OF INJURY



Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

This Notification of Injury Form is to be used for accident medical claims.

Policies With 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 insurance or medical payment plan they must first submit claim to the primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Deductible

If the claimant is paying the deductible prior to submitting any claims for processing, please complete the back of this form. This will ensure that 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 and signed by the Policyholder official or a staff member. Part (B) must be completed in full and signed by the injured person or the parent or guardian if the injured person is a minor. A full completed claim form is not necessary when submitting additional medical bills, only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. 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 HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be suspended, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish processing 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 to be 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 EOB's (explanation of benefits) attached?* _____
- Is part (A) of the claim form completed and signed by the Policyholder official or staff member?* _____
- Is part (B) of the claim form completed and signed by the injured person?* _____
- Are the attached medical bills itemized in either a HCFA 1500 or UB92 form?* _____
- Is part (B), item number 3 (social security number) completed?* _____

NOTICE

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."

PART A — This PART MUST be completed, dated and signed by an official or the Organization.				
1. Name of Organization (Policyholder) <p style="text-align: center;">Metro Junior Wrestling League</p>				
2. Policy No. <p style="text-align: center;">AHD0015414</p>				
3. Name of Organization or Team (if different from Policyholder) <p style="text-align: center;">P.O. Box 773 Fort Lupton, CO 80621</p>				
4. Address of Organization		(Street)	(City) (State) (Zip)	
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: <p style="text-align: center;">Wrestling</p>	
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident 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 to the accident Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Signature of Organization Official X _____		15. Title of Official	16. Area Code/Telephone No. ()	17. Date Signed

