Notification of Injury

This Notification of Injury Form is to be used for accident medical claims. **This form and all other correspondence must be submitted within 90 days from the date of accident.**

INSTRUCTIONS

1. **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 health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.
2. **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.
3. **Claim Form**
   This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. 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. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.
4. **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 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.
5. **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 checklist below to assure a properly submitted medical claim is being sent:

If the injured person has primary health insurance, has the claim been submitted first to the primary health insurance company?	☐ Yes	☐ No
If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached?	☐ Yes	☐ No
Is part (A) of the claim form completed by the Policyholder official or staff member and signed?	☐ Yes	☐ No
Is part (B) of the claim form completed by the injured person and signed?	☐ Yes	☐ No
Are the attached medical bills itemized in either a CMS 1500 or UB04 form?	☐ Yes	☐ No
Is part (B), item number 3 (Social Security number) completed?	☐ Yes	☐ No

MAILING THE CLAIM

Mailing the Claim
When completed in full, mail the attached completed claim form, itemized medical bills, and copies of EOB's (explanation of benefits, for use if coverage is excess) to:

Cambridge Administrators, LLC
1822 N 169 Plaza
Omaha, NE 68118

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 **(855) 868-7554**.

Documents may also be faxed to the claims office at **(402) 504-6447**. Please do not fax full medical claims, as often times medical bills are illegible when faxed. For emailing documents, please email **info@cambridgeadministrators.com**

PLEASE NOTE: Claims Must Be Submitted Within 90 Days Of The Date Of Accident.

NOTICE

WARNING: 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 may be a crime.

PART A – This part MUST be completed, dated, and signed by an official or the Organization

1. Name of Organization and Policy Number		
2. Address of Organization (Street)	(City)	(State)
3. Name of Injured Person (Insured) (First)	(Middle)	(Last)
4. Date of Accident/Injury Month Day Year / /	5. Injury Occurred Practice ☐ Travel ☐ Game ☐ Other _____	6. Type of Sport/Activity
7. Explain how the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.		
8. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐	9. Name of Supervisor of Activity	10. Was he/she a witness Yes ☐ No ☐

11. Signature of Organization Official X _____	12. Title of Official	13. Telephone Number ( )	14. Date Signed

PART B – This part MUST be completed, dated, and signed by the Injured Person, or by Injured Person's Parent or Guardian if he/she is under age 18 or otherwise dependent

Print Name of Person Completing Form Check one: ☐ Injured Person ☐ Parent ☐ Guardian

Please provide the following information about the Injured Person:

1. Date of Birth Month Day Year / /	2. Gender ☐ Male ☐ Female	3. Social Security No. or Student Visa No. / /	4. Telephone Number ( )

Please note the Injured Person's Social Security # MUST be provided, as required by the Center for Medicare Services.

5. Address (Street) (City) (State)

6. Employer Name (Street) (City) (State)

Employer Telephone Number ( )

7. Is the Injured Person covered under any other health and/or accident insurance plans? ☐ Yes ☐ No
If YES, please provide the following:

Name of Other Insurance Company(ies)	Address of Other Insurance Company(ies)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, please provide the following:

Name of Father or Male Guardian Place of Employment

Address of Employer Employer Phone Number ( )

Name of Mother or Female Guardian Place of Employment

Address of Employer Employer Phone Number ( )

9. If the Injured Person is married, please provide the following:

Name of Wife/Husband Place of Employment

Address of Employer Employer Phone Number ( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance 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 ☐ Parent ☐ Guardian

X _____ _____ _____

Signature (in writing) of Responsible Party Print Name Date