Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:

PRINT FORM

CLEAR FORM

SUBMIT ONLINE

NAHGA Claim Services

NAHGA Claim Services
P.O. Box 189
Bridgton, Maine 04009-0189
(800) 952-4320
(207) 647-4569 Fax

IMPORTANT NOTICE:
The student insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

If this form is not completed in FULL, this claim cannot be processed and will be returned.

PART 1: POLICYHOLDER & INSURED

(1) School/Organization | (2) Policy Number

(3) Student - Last Name, First Name | (4) Student Social Security Number

(5) Mailing Address where Insurance Info/Requests should be mailed | (6) City, State, Zip | (7) Phone

(8) Birthdate | (9) Male ❑ Female ❑ | (10) Was a Pre-Participation Physical performed clearing athlete for participation? Yes ❑ No ❑

(11) Date & Time of Injury | (12) Where did injury occur? | (13) How did injury occur?

(14) Part of body injured | (15) Date of first medical treatment | (16) Is this condition: Acute Injury ❑ or Chronic/Overuse Condition ❑

(17) Has health history been recently reviewed by sports medicine staff? Yes ❑ No ❑

(18) Has the athlete injured the same body part in the past? Yes ❑ No ❑
(if yes, please attach a copy of the pre-participation physical showing clearance)

(19) Sport Type: _____ Designation: Intramurals ❑ Practice ❑ Game ❑ Other ❑ _____

(20) Was the Student involved in an activity sponsored and supervised by the school at the time of injury? Yes ❑ No ❑

(21) Under whose supervision? | Was He/She a witness? Yes ❑ No ❑

(22) Signature of Supervisor/Official: | Title | Date

PART 2: PARENT OR GUARDIAN STATEMENT

(1) Father/Guardian Name Telephone	(2) Mother/Guardian Name Telephone
(3) Home Address (Street, City, State, Zip)	(4) Home Address (Street, City, State, Zip)
(5) Employer	(6) Employer
(7) Father's Employer Address (Street, City, State, Zip)	(8) Mother's Employer Address (Street, City, State, Zip)
(9) Business Phone	(10) Business Phone

(11) Is Student covered by any other insurance policy (other than this school policy), either as a dependent, group, individual, automobile medical or liability? Yes ❑ No ❑

If yes, please list name of insurance carrier: _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.

PART 3: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when requested to do so, any information to NAHGA CLAIM SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. I understand this information will be utilized for the purpose of claim administration and agree that there are no specified limitations. This authorization shall be valied for 102 weeks. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.

X _____ _____

Signature of Student or Authorized Person | Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____ _____

Signature of Student or Authorized Person | Date

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill. V.03.16