



MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com

**BOTH SIDES OF CLAIM FORM
MUST BE COMPLETED AND
RETURNED WITHIN 30 DAYS.**

Payor ID# 22384

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

☐ GRADUATE
☐ UNDERGRADUATE

- PLEASE PRINT ALL INFORMATION -

PARTS I & II - MUST BE COMPLETED AND SIGNED BY STUDENT

Name of College or University, City and State _____ Domestic ☐ International ☐ Policy Number _____ Birth Date _____

Insured Student's Name _____
LAST NAME FIRST NAME M.I. STUDENT ID # PHONE #

Present Address _____
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

Home Address _____
NO. AND STREET CITY OR TOWN STATE ZIP # + 4

If claim for dependent, give dependent's name _____, relationship to Insured _____ Age _____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Describe nature of injury and how it occurred _____

Date and hour of occurrence _____

Was the injury due to practice or play of a sport? ☐ Yes ☐ No

Which sport? _____

☐ Intercollegiate ☐ Intramural ☐ Club ☐ Other

Is condition work related? ☐ Yes ☐ No

Is condition due to auto accident ☐ Yes ☐ No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

Were you treated in the Health Service for this condition? ☐ Yes ☐ No

Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ☐ Yes ☐ No

If not, why? Away from school ☐
For what reason: _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of sickness _____

Date symptoms first noticed _____

If pregnancy, date of last menstrual period _____

What is the exact nature of the sickness? _____

Have you ever had the same or similar condition? ☐ Yes ☐ No

If yes, date of first treatment _____

Date of last treatment _____

Were you treated in the Health Service for this condition? ☐ Yes ☐ No

Seen by: _____ Date: _____

If your claim is for services outside of the Health Service, were you referred? ☐ Yes ☐ No

If not, why? Away from school ☐
For what reason: _____

**Administrative Concepts, Inc. does not share private health information except as required or permitted by law.
We are committed to guarding the private information entrusted to us.**

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____
STREET CITY STATE ZIP CODE + 4

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?

☐ Yes ☐ No

If yes, indicate the name and address of the company _____

Effective date of coverage: _____ Expiration date: _____ Policy No. _____

Have you filed a claim with any other insurance company? ☐ Yes ☐ No

I hereby certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

The following section is applicable if you are covered under any other medical insurance plan.

Mother's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

Father's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

Spouse's Name _____ Employer's Telephone # _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

_____ Policy No. _____

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: 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 and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a 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, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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: 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.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** 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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 a denial of insurance benefits.

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.