# How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

**WebTPA**
P.O. Box 669
Grapevine, TX 76099-0669
Customer Service: (877) 563-7492
Fax: (469) 417-1989
**Email: helpme@webtpa.com**

**Step 1:** **Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

**The Participating Organization (not the Parent, Claimant or Agent) should:**

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

**Step 2:** **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

## HOW TO FILE A CLAIM

**All information must be provided for a claim to be processed.**

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer all questions and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to address below:
   **WebTPA**
   **P.O. Box 669**
   **Grapevine, Texas 76099-0669**
   **Customer Service: 877-563-7492**
   **Fax: 469-417-1989**
4. Advise all doctors / hospitals of this coverage so they may forward their itemized bills.
5. If you have already been to doctor / hospital and did not know about this coverage, send all itemized bills to address above.
6. Itemized bills should include name of doctor / hospital, complete mailing address, telephone number, date seen, what you were seen for (diagnosis) and specific itemized charges incurred. (Description of treatment including CPT codes and amount).
7. If you have other insurance, submit a claim to your other insurer. When an Explanation of Benefits is received from Primary Carrier, mail to address above along with all corresponding itemized bills and completed claim form. You must submit itemized bills which include:
   a) HCFA-1500 (standard form used by Providers)
   b) UB-04 or UB-92 (standard form used by Hospitals)
8. If you already paid the bill, include a paid receipt or copy of your cancelled check. Payment will be made to the Provider of Service unless a paid receipt statement accompanies the bill when claim form is submitted.
9. **Common Causes For Delays in Processing Claims**
   a) Claim Form not fully completed or not submitted.
   b) Balance Due, Balance Forward or Past Due statements submitted as itemized bills.
   c) Explanation of Benefits from Primary Carrier not provided with itemized bills.

**Keep Copies of All Correspondence For Your Own Records Until Claim Has Been Processed.**

CRUM & FORSTER
A FAIRFAX COMPANY

WebTPA
An AmWINS Group Company

## PART I – PARTICIPATING ORGANIZATION STATEMENT

| | | | | |
|---|---|---|---|---|
| **Policy Number:** US1860768 | **Policyholder / Organization Name:** Parkers Chapel School District | | **Event, Activity or Sport:** | |
| **Name of School:** Parkers Chapel | **Street Address** 209 Parkers Chapel Rd | **City** El Dorado | **State** AR | **Zip Code** 71730 |
| **Claimant's Name (Injured Person)** | **Social Security Number** | **Gender** ☐M ☐F | **Date of Birth** | **E-Mail Address** |

**Address of Injured Person and Best Contact Phone Number (Include Area Code)**

| | | |
|---|---|---|
| **Date and Time of Accident** | **Place where Accident Occurred** | **The injured person was a:** ☐ Participant ☐ Staff Member ☐ Other |
| **Dental Claims** | **Indicate which Teeth were Involved in the Accident** | **Describe Condition of Injured Teeth Prior to Accident:** ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial |

**Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)** | **Did Injury Result in Death?** ☐YES ☐NO

**Describe How Accident Occurred – Provide All Possible Details**

**Did Accident Occur (Check Yes or No for Each of the Following):**

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐YES ☐NO
B. On activity premises? ☐YES ☐NO
C. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
D. During a participating organization practice? ☐YES ☐NO or competition? ☐YES ☐NO

| **Signature of Participating Organization Representative** | **Name and Title of Participating Organization Representative** | **Date** |
|---|---|---|
| | | |

## PART II – OTHER INSURANCE STATEMENT

**Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐YES ☐NO**

**If Yes, name of insurance company::**_____ **Policy #:**_____

**Mother's (Guardian's) primary employer name, address & telephone:** _____

**Father's (Guardian's) primary employer name, address & telephone:** _____

**Are you eligible to receive benefits under any governmental plan or program, including Medicare?**

**☐YES ☐NO If yes, please explain:** _____

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.**

## PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

**SIGNATURE** _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **United States Fire Insurance Company** or its designated administrator**.** A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***United States Fire Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

**SIGNATURE** _____ **DATE** _____

**CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:**

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.

**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.

**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.

**CALIFORNIA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fins and confinement in state prison.

**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.

**FLORIDA WARNING** :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 of claim containing any false, incomplete, or misleading information is guilty of a felony.

**KANSAS:** 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 insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person 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

**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.

**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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO and 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.

**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:** 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.

**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.

**TEXAS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**VIRGINIA:** Any person who, with the 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 may have violated state law.