First Health | MultiPlan | HSR Health Special Risk, Inc. | UBA

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO *HSR*

E-mail : UBAclaims@hsri.com

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (866) 523-3452

Policy Name:
United Business Association

Policy Number:

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)	2. Social Security Number	3. Gender ☐M ☐F	4. Date of Birth	5. E-Mail

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

7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident	9. Place where Accident Occurred

Dental Claims	11. Indicate which Teeth were Involved in the Accident	12. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

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

14. Describe How Accident Occurred – Give All Possible Details

20. Name of Member	21. Signature of Member	22. Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant 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 your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	DATE

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. **(if not signed, submit proof of payment)**

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined 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. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

Insurance Claim Filing Instructions

A properly completed claim form will assist us in the prompt processing of your claim – Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.

Claim Form:

- The claim form should be fully completed, signed and dated. The claim form must be submitted within 90 days from the date of the injury.
- Only one claim form is required for each accident.
- Make a copy for yourself and mail to the address below.

Your Bills:

- Advise all physicians /hospitals of your coverage and provide them with Policy information so that they may submit their itemized bills to ***HSR*** for consideration ***OR*** you may submit the itemized bills yourself to the address below.
- All bills should include the name of the physician/hospital, their complete mailing address, telephone number, the date of service, reason for visit or diagnosis code and itemized list of billed charges including CPT procedure codes.
- We do not pay from Balance Due Statements from your physician or hospital.

Primary Insurance

- If this policy provides coverage on a primary basis, you should submit your claim form and bills to ***HSR*** first.
- ***HSR*** will process benefits on a primary basis and provide you with an EOB to submit to your secondary carrier.

Excess Insurance

- If this policy provides coverage on a secondary/excess basis and you have other insurance coverage you will need to send your bills to your primary insurance first.
- ***HSR*** will consider benefits after your primary insurance has processed them.
- ***HSR*** will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance advising you what they paid or denied.
- ***HSR*** is unable to consider your claim without this information. Balance Due Statements from your physician or the hospital showing the primary insurance payment is not acceptable. A copy of the actual Explanation of Benefits is required.

If you have any questions, please contact Customer Service at (800) 328-1114. They are available from 8:00 a.m. to 6:00 p.m., Monday – Friday. You may also fax documents to (972) 512-5820.

Return Claim Form to:
Health Special Risk, Inc
4100 Medical Parkway
Carrollton, Texas 75007

Fraud Warning for Claim Forms

Generic:

WARNING – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

For AL residents:

> ***Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.***

For CA residents:

> ***Warning – 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.***

For FL residents:

> **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.**

For KS residents:

> ***WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud as determined by a court of law, which is a crime and subjects the person to civil and criminal penalties.***

For KY residents:

> **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.**

For LA residents:

> ***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.***

For ME residents:

> ***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.***"

For NJ residents:

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

For NM residents:

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 CIVIL FINES AND CRIMINAL PENALTIES.

For NC resident:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and may subject the person to civil and criminal penalties.

For OH residents:

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."

For OK residents:

WARNING: 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."

For OR residents:

WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.

For PA residents:

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.

For RI residents:

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.

For TN residents:

> ***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.***

For VA residents:

> ***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.***"

For VT residents:

> ***WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may commit insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.***

Generic States:

AK
AR
AZ
DE
DC
GA
HI
IL
IA
ID
IN
MA
MI
MS
MO
MT
NV
NE
ND
SC
SD
TX
UT
WI
WV
WY

Not known as we do not have approved forms in these states:

CO
MD
MN
NH
NY
WA