PROOF OF LOSS

Specialty Risk International, Inc.
9200 Keystone Crossing, Suite 300
Indianapolis, IN 46240
800-335-0477 or 317-575-2656 Fax: 317-575-2659

Insurance Carrier: _____
Certificate Number: _____
Group Number: _____

ACCIDENT AND ILLNESS CLAIM FORM

Instructions:

1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
2.) Section A must be completed by the Insured in full.
3.) One of the following must be provided:
A.) Section B fully completed by the Attending Physician, or B.) Fully itemized bills including: Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
4.) This form must be signed and dated in all applicable sections.
5.) This form and all attached bills must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to cominal and substantial civil penalties.

SECTION A

Coverage Effective Date ___/___/___ Coverage Termination Date ___/___/___

1.) Name of Insured: _____ Date of Birth ___/___/___ Sex: ___Male ___ Female

2.) Name of Claimant: _____ Date of Birth ___/___/___ Sex: ___Male ___Female

3.) Current Residence Address: _____

Date of Arrival in U.S.: ___/___/___ Daytime Phone Number: (_____)_____

4.) Permanent Address (In Home Country): _____

Date scheduled to return to Home Country: ___/___/___

5.) If Accident, provide details, i.e., how when and where accident occurred:_____
_____

6.) If Illness, advise when and where symptoms first occurred and nature of illness:_____
_____

7.) Name and address of Consulting Physicians:_____
_____

8.) Have you ever been treated for this Illness before? Yes___ No___ If Yes, when?_____

9.) Provide Name and Address of your Regular Physician in your Home Country: _____
_____

10.) Please advise names of any prescription medications you are presently taking: _____
_____

11.) Indicate other Health Insurance coverage, include name, address, policy number and certificate number of Insurer:_____
_____

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator furnish to the Claims Administrator named above or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrators to provide the Claims Administrator named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

_____ _____
Signature of Claimant or Parent, If Claimant is a Minor Date

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

_____ _____
Signature Date

Section B

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS CHAMP ☐ (Sponsor's SSN)	VA GROUP HEALTH PLAN ☐ (VA File #) (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)	3. PATIENT'S DATE OF BIRTH MM DD YY / /	SEX M ☐ F ☐	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ (SPECIFY)		7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part-Time Student ☐		CITY STATE
ZIP TELEPHONE NUMBER ( )			ZIP TELEPHONE NUMBER ( )
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER	A. PATIENT'S EMPLOYMENT? YES ☐ NO ☐		A. PATIENT'S DATE OF BIRTH MM DD YY / / SEX M ☐ F ☐
B. OTHER INSURED'S DATE OF BIRTH MM DD YY / / SEX M ☐ F ☐	B. AN AUTO ACCIDENT? YES ☐ NO ☐		B. EMPLOYER'S NAME OR SCHOOL NAME
C. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT? YES ☐ NO ☐		C. INSURANCE PLAN NAME OR PROGRAM NAME
D. INSURANCE PLAN NAME OR PROGRAM NAME	D. RESERVED FOR LOCAL USE		D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return & complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature: _____ Date: _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to undersigned physician or supplier for services described below. Signature: _____ Date: _____

14. DATE OF CURRENT MM DD YY / / ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY / /	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM: / / TO: / /
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM: / / TO: / /
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____.____ 2. _____.____ 3. _____.____ 4. _____.____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICES FROM MM/DD/YY	TO MM/DD/YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H DPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
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25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES ☐ NO ☐	28. TOTAL CHARGES $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof) Signed: _____ Date:_____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).	33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE# PIN # GRP#

PLACE OF SERVICE CODES

1-(H) - INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5-DAYCARE FACILITY (PSY)
6-NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9-AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B-OTHER