



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

All bills must **first** be submitted to any Group, Hospital, and/or Medical Plan to which the claimant may be eligible. The primary insurer's Explanation of Benefits indicating payments and/or denials must accompany this claim form. **This form must be completed and signed by a Supervising Official of Participating Institution.**

*Please return this completed claim form to:*

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

**Phone: 855-760-9862 Fax: 610-293-9299 Email: claims@visit-aci.com**

**Complete in detail to insure prompt handling EDI PAYOR ID# 22384**

Any person who knowingly presents a false or fraudulent claim for payment of 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.

**PART I**

Name of College or University, City and State

**Los Angeles Community College District**

Policy Number

**SDAN06568154; SDAN06568166 (CAT)**

Select location:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> City College 1000001       | <input type="checkbox"/> East L.A. College 1000002 | <input type="checkbox"/> Harbor College 1000003    |
| <input type="checkbox"/> Mission College 1000004    | <input type="checkbox"/> Pierce College 1000005    | <input type="checkbox"/> Southwest College 1000006 |
| <input type="checkbox"/> Trade-Tech College 1000007 | <input type="checkbox"/> Valley College 1000008    | <input type="checkbox"/> West L.A. College 1000009 |

Claimant's Full Name	Street Address	City	State	Zip + 4
Date of Birth	Social Security # or Student I.D. #	Phone #	Email Address	
Parent or Guardian's Full Name	Street Address	City	State	Zip + 4
Phone #	Email Address			

1. Give full description of injury:

2. Give exact date and time when injury occurred. Date: \_\_\_\_\_ Time: \_\_\_\_\_ am ( ) pm ( )

3. Date when claimant first consulted a physician for this condition? \_\_\_\_\_

4. Has the claimant been previously troubled with this condition? Yes ( ) No ( ) Date: \_\_\_\_\_

Location where treatment was received: \_\_\_\_\_

**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 THE 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., the underwriting company, a supervising official, and USI of Southern California. 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

*Please Print All Information*

**PART II**

Did accident occur (check yes or no)	Y	N		Y	N
(a) While claimant was supervised?	( )	( )	(f) Accident/Non-Sport?	( )	( )
(b) During sponsored activity?	( )	( )	(g) Intercollegiate Sport?	( )	( )
(c) During programmed hours?	( )	( )	(g1) Competition?	( )	( )
(d) On college premises?	( )	( )	(g2) Practice?	( )	( )
(e) While traveling to or from a regularly scheduled activity in a supervised group?	( )	( )			

Type of sport or activity: \_\_\_\_\_

Name and Title of Supervising College Official

Name: \_\_\_\_\_ Title: \_\_\_\_\_

I hereby certify that the statements made are correct to the best of my knowledge and belief, that the above named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on:

\_\_\_\_\_, \_\_\_\_\_  
Date of Injury

Signature of College Official: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**PART III**

Nature of injury/Diagnosis: \_\_\_\_\_

IC9 Codes: \_\_\_\_\_

Part of body

( ) Head	( ) Neck	( ) Arm	( ) Wrist
( ) Hand	( ) Leg	( ) Knee	( ) Ankle
( ) Other: _____			

Sport or Activity: \_\_\_\_\_

Athlete's position: \_\_\_\_\_

Gender ( ) Male ( ) Female

Age: \_\_\_\_\_ Grade / College Year: \_\_\_\_\_

Time classes commence on date of injury:

\_\_\_\_\_ am \_\_\_\_\_ pm

Date of Injury: \_\_\_\_\_

Where did injury occur:

( ) Game ( ) Practice ( ) Drills ( ) Playground ( ) Field Trip ( ) Weight Room / Training ( ) Gym / PE Class  
( ) Other: \_\_\_\_\_

Playing Surface:

( ) Grass ( ) Turf ( ) Hardwood  
( ) Other: \_\_\_\_\_

Season or Pre-Season:

( ) Season ( ) Pre-Season

Medical treatment available / provided: \_\_\_\_\_

Claims and payments by provider: \_\_\_\_\_

**PART IV**

Is claimant currently covered by any other insurance plan? ( ) Yes ( ) No

Is claimant currently covered by MediCal, Medicaid, Medicare or any other Government Insurance? ( ) Yes ( ) No

Name of Insurance Company: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of person carrying other insurance coverage: \_\_\_\_\_

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

**WARNING. Any person who knowingly:**

**Alabama:** 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.

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

**California:** For your protection California law requires the following to appear on this form:

Any person who knowingly presents 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.

**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.

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

**Florida:** and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any 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 material fact 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.

**Louisiana, New Mexico, Texas and West Virginia:** presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA:** 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.)

**Maryland:** and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and 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 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.

**Oregon:** and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

**Puerto Rico:** and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**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.

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

**Maine/Washington:** 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.

**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. Penalties include imprisonment, fines and denial of insurance benefits.