

Preferred Care, Inc. College/University Accident Claim Form

Complete Both Sides of this form. Attach bills and insurance payment records.

Mail to: Preferred Care, Inc.
Six Neshaminy Interplex
Suite 205
Trevose, PA 19053
(800) 222-3085



American Sentinel Insurance Company

Any Person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act.

Claim Form Instructions

- Part I - Must be completed by a school official.
- Part II- Must be completed by the claimant or by the parent or guardian if the claimant is a minor.
- The claim must be submitted within 90 days from the date of injury or as soon as reasonably possible and the first expense must be incurred within 30 days from the date of injury.
- Attach itemized bills showing diagnosis, treatment, dates of treatment, and charges with corresponding explanation of benefits statement to this claim form. Forward all additional bills with record of payment from your primary insurance.
- Please note the name of the college/university on all bills and correspondence.
- All benefits will be made payable to the physicians and providers involved, unless accompanied by paid receipts.

PART I - COLLEGE/UNIVERSITY REPORT

1. Name of College/University		2. Address <small>Street City State Zip</small>					
3. Name of Insured	Last	First	M	4. Social Security No.	5. Grade	6. Birthdate	7. Sex
8. Nature of Injury (Please describe, fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.)							
9. Describe how accident occurred. (Give all possible details.) Must be a bodily injury due to accident.							
10. Did Accident occur:		Yes	No	11.		12. Name of Activity	
a) While claimant was school supervised?		<input type="checkbox"/>	<input type="checkbox"/>	a) Date of Accident:		13. Supervisor Name: Title:	
b) During school sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>	b) Time:			
c) During programmed school hours?		<input type="checkbox"/>	<input type="checkbox"/>	c) Place:			
d) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?		<input type="checkbox"/>	<input type="checkbox"/>				
e) On activity premises?		<input type="checkbox"/>	<input type="checkbox"/>				
f) Off school premises, at home, during the weekend, holiday, or summer vacation?		<input type="checkbox"/>	<input type="checkbox"/>				
14. Signature of School Officer			15. Title			16. Date	

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL

PART II - TO BE COMPLETED BY CLAIMANT - OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian				2. Social Security No.			
3. Name of Mother or Guardian				4. Social Security No.			
5. Address of Parents or Guardian/ or Claimant				5A. Telephone Number			
Number & Street		City	State	Zipcode			
6A. Name and Address of Father or Guardian's Employer				6B. Name and Address of Mother or Guardian's Employer			

7A. Father or Guardian's Insurance Company	7B. Mother or Guardian's Insurance Company	6C. Type of Insurance: <input type="checkbox"/> Individual <input type="checkbox"/> Group
--	--	---

8. List other insurance policies under which claimant is insured:

Company	Policy No.	
1. _____	1A. _____	<input type="checkbox"/> Individual <input type="checkbox"/> Group
2. _____	2A. _____	<input type="checkbox"/> Individual <input type="checkbox"/> Group

Affidavit: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent or Guardian	Date
---------------------------------	------

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representatives any information requested. A photocopy of this authorization is considered valid.

Signature of Claimant (Parent or Guardian if Claimant is under 18)	Date:
--	-------

PART III - TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER
*****ITEMIZED BILLS SHOWING DIAGNOSIS, TREATMENT, DATES OF TREATMENT, AND CHARGES MAY BE SENT IN THE PLACE OF THE INFORMATION REQUIRED BELOW*****

1. Date of Injury:	2. Date First consulted for this condition:	3. Has patient ever had the same or similar conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Was there any congenital, pre-disposing or pre-existing condition relevant to this injury?		5. For services related to hospital-ization give hospitalization dates: Admitted: Discharged: Name & Address of Facility:
6. Name of Referring Physician:		
7. Are these charges being submitted for consideration by another insurance carrier?		

8. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column by reference to numbers 1 2 3, etc.

1. _____

2. _____

3. _____

4. _____

9A. Date of Service	9B. Place of Service	9C. Proc.Code	9D. Procedure Description	9E. Diag.Code	9F. Fee
1.					
2.					
3.					
4.					

10. Signature of Physician or Supplier Signed: _____ Dated: _____	11. Place of Service Codes 1-(H) - Inpatient Hospital 2-(OH) - Outpatient Hospital 3-(O) - Doctor's Office	12. Total Charge:
--	---	-------------------

13A. Patient Account #: _____ 13B. Patient Name: _____ 13C. Patient Age: _____	14. Provider Tax ID No:	15. Physician's or suppliers name, address, zipcode & telephone #
--	-------------------------	---