

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
(UB04 OR HCFA-1500 FORM)
3. EMAIL COMPLETED FORM TO:
Margaret Schubkegel
RPS Bollinger Sports & Leisure
Email: Margaret_Schubkegel@rpsins.com



Policy Name: _____

Policy Number: _____

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)		2. Social Security Number		3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. Email
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			10. The injured person is a: <input type="checkbox"/> Youth Player <input type="checkbox"/> Coach	
Dental Claims	11. Indicate which Teeth were Involved in the Accident		12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
13. Type of Injury (Indicate Part of Body Injured – e.g., (broken arm, sprained ankle, etc.)					Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Describe How Accident Occurred – Give All Possible Details						
15. Did Accident Occur (Check Yes or No for Each of the Following): A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? <input type="checkbox"/> YES <input type="checkbox"/> NO B. On activity premises? <input type="checkbox"/> YES <input type="checkbox"/> NO C. While on the job (if applicable)? <input type="checkbox"/> YES <input type="checkbox"/> NO D. While traveling directly and uninterruptedly to or from home and policyholder premises? <input type="checkbox"/> YES <input type="checkbox"/> NO E. During intercollegiate/scholastic athletic practice? <input type="checkbox"/> YES <input type="checkbox"/> NO or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO						
16. Name of Event or Activity				17. League Official Signature if Player is Claimant		
18. Name of USA Softball Team/League and Claimant's Individual Registration Member ID (include copy of ID Card)**						
19. USA Softball Commissioner's signature			20. USA Softball Commissioner's Name		21. 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.

New York Fraud Warning Notice: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material fact material thereto, commits a fraudulent insurance act, which is a crime and 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

SIGNATURE OF PARTICIPANT OR PARENT	DATE
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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 _____

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD WARNING NOTICES

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.

STATE SPECIFIC PROVISIONS

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	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.
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.
Arkansas Louisiana	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.
California	For your protection California law requires the following to appear on this form: 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.
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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia	WARNING: 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	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Indiana	A person who knowingly and with intent to defraud an insurer. files a statement of claim containing any false, incomplete, or misleading information commits a felony.
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.
Maine	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 denial of insurance benefits.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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.
Michigan North Dakota South Dakota	Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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.
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	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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
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.
Rhode Island West Virginia	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.
Tennessee Virginia 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 include imprisonment, fines and denial of insurance benefits.
Texas	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 fines and confinement in state prison.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

HOW TO FILE A CLAIM

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.
Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. The claim form must be signed by your USA Softball Commissioner.
3. Only one claim form for each accident needs to be submitted.
4. Once completed, email to Margaret Schubkegel with RPS Bollinger at Margaret_Schubkegel@rpsins.com.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.
 1. **Please note that an itemized bill is defined as a bill/claim form from the provider via a UB04 or HCFA-1500 claim form. Submitting itemized bills in any other format will delay the claims process. Providers are familiar with this process, so please be sure to (1) contact the provider and share the details above and request that the provider submit outstanding balances directly to **HSR**; or (2) secure a copy of the UB04 or HCFA 1500s provided to the primary insurer and submit a copy to **HSR** for consideration. (See attached examples of a UB04 or HCFA-1500)**
3. Due to HIPAA Privacy laws **HSR** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim. **HSR** cannot pay your bills using only the Primary Insurance Carrier’s EOB.

EXCESS INSURANCE

1. If the policy provides coverage on a secondary/excess basis and you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why. **HSR** will not be able to consider your claim without this information

If you have any questions in regards to a submitted claim, please contact HSR Customer Service at (866) 523-3199. They are available from 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday.

***For coverage questions, contact:
RPS Bollinger Sports & Leisure
1-800-446-5311***

***To check status of a claim contact:
Health Special Risk, Inc.
8400 Belview Drive, Suite 150
Plano, Texas 75024***

Frequently Asked Questions (FAQ):

What is an Explanation of Benefits?

- An explanation of benefits is a document that explains how your insurance processed the claim for the services you received.
- It breaks down the information like this:
 - o The services provided
 - o What the doctor or hospital charged (all charges)
 - o What your primary insurance covered and did not cover
 - o What your insurance agreed to pay
 - o The amount the claimant must pay (amount you are responsible for)

When Will I Receive an EOB From My Primary Insurance?

- Each insurance company is different but typically, you will receive an EOB within 30-60 days after receiving care provided your medical provider filed the claim with your primary insurance carrier.

Information the EOB Contains:

While all benefit statements look a little different, they will all contain the same basic types of information:

- **Account Summary** – This will list your name, address, member ID, claim number and insurance group number.
- **Claim Details** - This will include the services rendered, provider's name, location, date and any applicable reference number or medical procedure codes.
- **The Amounts:**
 - o charged by the facility or physician.
 - o the amount your primary insurance has agreed to pay per their contract with the provider/facility; and
 - o your financial responsibility.

Why Can't HSR Accept a Statement from My Provider Showing the Amount Owed (Balance Due Statement)?

- A balance due statement does not include the necessary coding information to process the secondary insurance claim and also includes provider payment information, including their Tax Identification Number which is required to finalize the claim.

FAQ (Continued):

What is an Itemized Bill?

An itemized bill is a full detailed listing of all actual charges that a patient or their primary insurance is being billed for based on the care received. Typically, these come in the form of a CMS HCFA-1500 for physician services or UB04 for facility charges. See below examples.

HEALTH INSURANCE CLAIM FORM									
<div> <div> <input type="checkbox"/> MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Service's SSN) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (Group ID) <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) </div> <div> <input type="checkbox"/> PICA <input type="checkbox"/> (PICA #) </div> </div>									
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)				2. PATIENT'S DATE OF BIRTH (MM/DD/YY)		3. PATIENT'S SEX (M/F)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED (Self/Spouse/Child/Other)		7. INSURED'S ADDRESS (No. Street)		8. INSURED'S CITY, STATE, ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO? (YES/NO)		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH (MM/DD/YY)	
13. EMPLOYER'S NAME OR SCHOOL NAME				14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO)		15. INSURED'S OR AUTHORIZED PERSON'S 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.)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM/TO)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				18. NUMBER OF REFERRING PHYSICIAN		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO)		20. OUTSIDE LAB? (YES/NO)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 BY LINE)				22. MEDICAD RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER		24. CHARGES	
25. DATE OF CURRENT ILLNESS (First symptoms or injury) (Accident or Pre-Existing Condition)				26. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM/DD/YY)		27. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM/TO)		28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM/TO)	
29. PATIENT'S ACCOUNT NO.				30. ACCEPT ASSIGNMENT? (For gmt. claim, see back)		31. TOTAL CHARGE		32. AMOUNT PAID	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made in good faith.)				34. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		35. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		36. BALANCE DUE	

Sample CMS HCFA Billing

1		2		3. PAY CRTL #		4. TIME OF BIRTH	
5. PAY REC #		6. STATEMENT COVER PERIOD FROM		7. STATEMENT COVER PERIOD THROUGH		8. STATEMENT COVER PERIOD THROUGH	
9. PRESENT NAME				10. PRESENT ADDRESS			
11. BIRTHDATE				12. CREATION CODES			
13. SEX				14. DATE			
15. AGE				16. DATE			
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