

# Dental Accident Claim Form

## Claimant's Statement

(Please print – Attach separate sheet if additional space required)

### CLAIMANT'S STATEMENT

Claimant's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex:  M  F

Claimant's Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Parent/Guardian Name \_\_\_\_\_ Best Contact Phone No.: ( ) \_\_\_\_\_

Name/City/State of school \_\_\_\_\_

Policy Number \_\_\_\_\_

### CLAIM INFORMATION

Date and Time of accident \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_  AM  PM

Please describe the location (playground, gym, etc.) and circumstances of accident (attach separate sheet if needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Below information Must be completed by School Official**

Printed Name of School/Camp Official: \_\_\_\_\_ Title: \_\_\_\_\_

School/Camp Official's Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_

**WE MUST RECEIVE EMERGENCY ROOM OR OTHER FIRST TREATMENT NOTE (URGENT CARE, DOCTOR'S OFFICE) AND ANY OTHER MEDICAL RECORDS TO DEMONSTRATE CARE AND TREATMENT OF ACCIDENT RELATED INJURIES.**

### FILING INSTRUCTIONS

- ▶ THIS CLAIM FORM MUST BE RECEIVED WITHIN 90 DAYS OF THE DATE OF ACCIDENT.
- ▶ THE RESPONSIBLE PARENT/GUARDIAN SHOULD COMPLETE THIS PAGE IN FULL.
- ▶ THE ATTENDING DENTIST SHOULD COMPLETE THE ATTACHED DENTIST'S STATEMENT. THE DENTIST MAY SUBMIT THE FORM DIRECTLY TO OUR OFFICE, OR YOU MAY RETURN IT WITH THIS CLAIM FORM AND OTHER DOCUMENTS.
- ▶ WE MUST RECEIVE ITEMIZED BILLS. WE CANNOT CONSIDER BALANCE DUE STATEMENTS WHICH ARE TYPICALLY NOT ITEMIZED. YOUR PROVIDER MAY FILE DIRECTLY ON YOUR BEHALF.
- ▶ MAKE COPIES OF THE AUTHORIZATION TO RELEASE INFORMATION FORM BEFORE COMPLETING THE PROVIDER SECTION IF YOU PLAN TO HAVE DOCUMENTS FROM MORE THAN ONE PROVIDER SUBMITTED FOR CONSIDERATION OF THIS CLAIM. PLEASE CALL US IF YOU NEED ADDITIONAL FORMS. GIVE THE AUTHORIZATION FORM TO ANY PROVIDER WHOSE RECORDS YOU WOULD LIKE TO SUBMIT WITH YOUR CLAIM (IF APPLICABLE).\*

**RETURN ALL DOCUMENTS TO:**

Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087

**TOLL FREE CUSTOMER SERVICE (888) 293-9229**

**Fax: (610) 293-9299**

**Email: aciclaims@visit-aci.com**

ASSIGNMENT OF BENEFITS / CLAIMANT SIGNATURE

I certify that the information provided above is true and that the circumstances of the accident are as described herein. I acknowledge receipt of the attached Fraud Warnings Disclosure, and I understand that the submission of information for the purpose of defrauding an insurance company may be subject to criminal investigation and or penalties.

\_\_\_\_\_  
Signature of Parent/Guardian/Responsible Party

\_\_\_\_\_  
Date

I assign payment of benefits directly to the service provider(s) associated with this loss and who provide standardized billing forms which include service itemization, coding, billing address and business tax identification number (TID) for tax purposes.

\_\_\_\_\_  
Signature of Parent/Guardian/Responsible Party

\_\_\_\_\_  
Date

# Dental Accident

## ATTENDING DENTIST'S STATEMENT

DENTISTS PLEASE NOTE: THIS IS A LIMITED POLICY. YOU MAY NOT RECEIVE PAYMENT IN FULL FOR SERVICES RENDERED. BALANCES AFTER BENEFIT DISTRIBUTION ARE THE RESPONSIBILITY OF THE PATIENT.

IN ORDER TO BE PAID DIRECTLY, YOU MUST SUBMIT THIS QUESTIONAIRE ALONG WITH STANDARDIZED BILLING FORMS WHICH CONTAIN ALL APPROPRIATE CODING, CHARGES, YOUR BILLING ADDRESS AND TAX IDENTIFICATION NUMBER.

|  |  |
|--|--|
| PATIENT'S NAME:  | REPORTED DATE OF INJURY:   |
| DESCRIBE THE EXACT NATURE OF THE INJURY:   |  |
| DATE YOU FIRST TREATED THE PATIENT FOR THIS COMPLAINT: _____ / _____ / _____   |  |
| WERE THE EFFECTS OF THE INJURY IMMEDIATELY APPARENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | IF NOT, WHEN DID THEY BECOME APPARENT?   |
| HAVE YOU EVER TREATED THE PATIENT FOR A SIMILAR CONDITION?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | IF YES, WHEN? PLEASE EXPLAIN:  |
| HAS THE PATIENT FULLY RECOVERED FROM THIS SPECIFIC INJURY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | IF NOT, WHAT FURTHER TREATMENT DO YOU EXPECT TO PROVIDE?   |
| IN YOUR PROFESSIONAL OPINION, WAS THIS CONDITION CAUSED SOLELY AND INDEPENDENTLY BY ACCIDENTAL INJURY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | IF NOT, PLEASE EXPLAIN ANY UNDERLYING MEDICAL CONDITION OR OTHER CAUSE YOU BELIEVE MAY HAVE CONTRIBUTED: |
| DESCRIBE THE CONDITION OF THE TOOTH PRIOR TO INJURY:<br><input type="checkbox"/> SOUND/NATURAL <input type="checkbox"/> FILLED <input type="checkbox"/> CAPPED <input type="checkbox"/> ARTIFICIAL<br><input type="checkbox"/> OTHER _____ |  |

|                         |                            |        |      |
|-------------------------|----------------------------|--------|------|
| Dentist must sign here: | Degree:                    |        |      |
| Address:                | City:                      | State: | Zip: |
| Date:                   | Tax Identification Number: |        |      |

TO EXPEDITE PROCESSING, YOU MAY RETURN THIS QUESTIONAIRE, ALONG WITH YOUR VISIT NOTES AND STANDARDIZED BILLING FORMS, DIRECTLY TO THE CLAIMS ADMINISTRATOR AT:

Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087  
TOLL FREE CUSTOMER SERVICE (888) 293-9229  
FAX (610) 293-9299  
EMAIL: aciclaims@visit-aci.com

**Catlin Insurance Company, Inc.**

**RELEASE OF INFORMATION**

**Authorization Form**

**INSURED INFORMATION**

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  Male  Female

Insured's Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

I hereby authorize \_\_\_\_\_

(TREATING FACILITY/ PHYSICIAN/OTHER HEALTHCARE PROVIDER NAME HERE)

and its affiliates, employees and agents to release health information which identifies diagnosis, treatment, claims payment and healthcare services already provided or to be provided to:

\_\_\_\_\_ for \_\_\_\_\_  
(Patient's full name) (dates of treatment)

Information should be released or mailed to:  Individual  Physician  Institution  Insurance Administrator

**Administrative Concepts, Inc.**  
**994 Old Eagle School Road, Suite 1005**  
**Wayne, PA 19087**

**Purpose:**  
 Claims Payment  Litigation  
 Medical Review  Other: \_\_\_\_\_

**I request only the following information be released:**

- ENTIRE MEDICAL RECORD  Lab reports  Operative Report  X-Ray Report
- Emergency Room Report  Pathology Report  EKG  X-Ray Film
- Admission History & Physical  Cardiac Cath Lab Reports  Itemized Billing Statement
- Discharge Summary  Other \_\_\_\_\_

I understand this release includes personally identifiable information such as name, address, social security number and insurance identification number. I also understand that this information may be subject to re-release by this entity for the purpose of resolving insurance benefit coverage determinations. As such, this information may no longer be protected by applicable state and/or federal privacy laws.

**This authorization shall be valid for one year (365 days) from the date of my signature below or until \_\_\_\_\_.**  
(insert date)

I have the right to revoke this authorization by providing written notice to the receiving entity listed above. However, this authorization may not be revocable if the entity, its employees or agents have already acted on this authorization prior to receiving my written revocation. I understand that this authorization is voluntary, and that I have a right to a copy of this authorization. Refusal to sign this authorization does not affect my eligibility for enrollment or payment of covered services.

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If other than member, please sign below and include a copy of written proof of legal authorization to represent the member or his or her estate (i.e. Power of Attorney, Guardianship, Executor, other)

Name of Legal Representative, if applicable: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Witness, if signed by Representative: \_\_\_\_\_

Signature of Witness, if signed by Representative: \_\_\_\_\_ Date: \_\_\_\_\_

# NOTICE TO POLICYHOLDERS

## FRAUD NOTICE

|                             |  |
|-----------------------------|--|
| <b>Alaska</b>               | 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.  |
| <b>Arizona</b>              | 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.   |
| <b>Arkansas</b>             | 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.   |
| <b>California</b>           | 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.  |
| <b>Delaware</b>             | 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.  |
| <b>District of Columbia</b> | <b>WARNING:</b> 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. |
| <b>Florida</b>              | 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.  |
| <b>Idaho</b>                | Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.   |
| <b>Indiana</b>              | Any 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.  |
| <b>Kentucky</b>             | Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.              |
| <b>Louisiana</b>            | 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.   |
| <b>Maine</b>                | 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.  |
| <b>Maryland</b>             | Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.   |
| <b>Minnesota</b>            | A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.   |
| <b>New Hampshire</b>        | 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.  |

## NOTICE TO POLICYHOLDERS

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|---------------------|--|
| <b>New Jersey</b>   | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.  |
| <b>New Mexico</b>   | 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.  |
| <b>New York</b>     | Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.  |
| <b>Ohio</b>         | 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.  |
| <b>Oklahoma</b>     | <b>WARNING:</b> 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.   |
| <b>Pennsylvania</b> | 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.  |
| <b>Puerto Rico</b>  | <b>Any person who knowingly 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 by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] 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.</b> |
| <b>Rhode Island</b> | 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.   |
| <b>Tennessee</b>    | 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.  |
| <b>Virginia</b>     | 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.  |

## NOTICE TO POLICYHOLDERS

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|                   |  |
|-------------------|--|
| <b>Washington</b> | 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.                          |
| <b>NAIC Model</b> | 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. |