Proof of Loss Volunteer Accident Claim Form

Submit Claim via Mail, Fax, or Email to:	Health Special Risk 8400 Belleview Drive, Suite 150 Plano, Texas 75024	Email: claims@hsri.com Fax: 972-512-5820 Phone: 800-328-1114
Claims Administered by:	Health Special Risk, Inc., Plano, TX on behalf of AXIS Insurance Company	

Instructions: The policy is Full Excess only. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your primary insurance company. When you receive the Benefits Statements (Explanation of Benefits or EOB) send it to us along with itemized bills.

- **Part I** – Must be completed by the **Sponsoring Organization**.
- **Part II** – Must be completed by the **Volunteer**.
- Send copies of itemized provider bills showing provider's name, address, tax ID, diagnosis & procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier, including any Medicare payment records.

PART I – SPONSORING ORGANIZATION REPORT – To be completed by sponsoring organization

Policy Type Check One:	☐ **RSVP**/CNS (SRPOAGI-ACR10000) Retired Senior Volunteer	☐ **SCP**/CNS (SRPOAGI-ACR10000) Senior Companion	☐ **FGP**/CNS (SRPOAGI-ACR10000) Foster Grandparent
	☐ **VIS** (SRPOAGI-ACR20000) Traditional Volunteer	☐ **CRASVP** (SRPOAGI-ACR30000) Court Referred Alt Sentencing	☐ **WRVP** (SRPOAGI-ACR50000) Work Release
	☐ **SDP**/CNS (SRPOAGI-ACR10000) Senior Demonstration		

Name of Sponsoring Organization as it appears on your policy documents			Client Code
Organization Street Address		City	State / Zip Code
Organization Contact Name	Phone	Fax	Contact Email

LAST Name of Volunteer	FIRST Name of Volunteer	
Social Security Number (REQUIRED)	Date of Birth (REQUIRED)	Sex ☐ F ☐ M

DATE of Accident	Place of Accident	Time of Accident ☐ AM ☐ PM	DATE of FIRST Treatment
Name & Title of Person Supervising Activity	List Anyone Present at Time of Accident	Was he or she a witness? ☐ Yes ☐ No	

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PART I – SPONSORING ORGANIZATION REPORT – CONTINUED

Nature of Injury. Describe fully, indicating specific body part(s) injured (e.g. broken left arm, sprained right ankle, etc.). **Must be a bodily injury due to accident.**

Describe HOW the accident occurred. Provide all details and attach a separate incident report if necessary.

Describe ACTIVITY Volunteer was registered for at the time of the accident (i.e. stocking shelves at food pantry; senior companion home visit).

PRINTED NAME of Authorized Sponsoring Organization Representative	**TITLE**
SIGNATURE of Authorized Sponsoring Organization Representative	**DATE**

PART II – TO BE COMPLETED BY VOLUNTEER

Please attach bills and/or Medicare Explanations of Benefits if available. Claims submitted with incomplete information will be returned for completion and may delay processing.

Volunteer LAST Name	**Volunteer FIRST Name**	**Phone Number**	**Email**		
Street Address		**City**		**State**	**Zip Code**

1. Does Volunteer have health insurance other than Medicare? ☐ **YES** ☐ **NO** **If YES, please identify insurer and PROVIDE COPY of INSURANCE CARD (front & back).** **Insurer: _____**		
2. Is Volunteer covered by:	**Medicare – Part A?** ☐ **Yes** ☐ **No**	**Medicare – Part B?** ☐ **Yes** ☐ **No**

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3. **Is the Volunteer enrolled in, a member of, or a participant of a PREFERRED PROVIDER ORGANIZAITON (PPO), HEALTH MAINTENANCE ORGANIZATION (HMO), or similar prepaid health plan as an individual, employee, or dependent?**

   PPO? ☐ YES ☐ NO If "YES", name of PPO: _____

   HMO? ☐ YES ☐ NO If "YES", name of HMO: _____

   If YES to any of the above, PROVIDE COPY of INSURANCE CARD(S) - front & back.

LAST Name of Volunteer	FIRST Name of Volunteer

PART III – AFFIDAVIT, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT AUTHORIZATION

I verify that the 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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extend for which the Company would not have been liable.

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment benefits payable, including disability or employment related information concerning the patient to any AXIS company, its employees, and authorized agents for the purpose of validation and determining benefits payable. I further authorize any AXIS company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless otherwise specified above.

VOLUNTEER'S SIGNATURE	DATE

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.

- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.

- ***For residents of California***: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For residents of 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.

- ***For residents of the 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.

- ***For residents of Florida:*** 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.

- ***For residents of Kentucky:*** 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.

- ***For residents of Maine, Tennessee and 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.

- ***For residents of Maryland:*** 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of New York:*** 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 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of Oregon:*** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of 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.

- ***For residents of 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.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

HSR
ACCIDENT INSURANCE SOLUTIONS

How to File a Claim

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

STEP BY STEP INSRUCTIONS FOR SUBMITTING A CLAIM

1. Fully Complete The Claim Form
2. Sign Claim Form
3. Include ITEMIZED Bills From Your Medical Provider
4. One Claim Form Per Accident
5. Keep a Copy For Your Records.
6. Submit Claim Form To:

   Health Special Risk
   8400 Belleview Drive, Suite 150
   Plano, Texas 75024

   Or email to **CLAIMS@HSRI.COM.**

FURTHER DETAILS BELOW

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 a policyholder representative.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to ***HSR*** at the address shown below.
3. 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 UBO4 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 UBO4 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 on next page.)**
4. 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

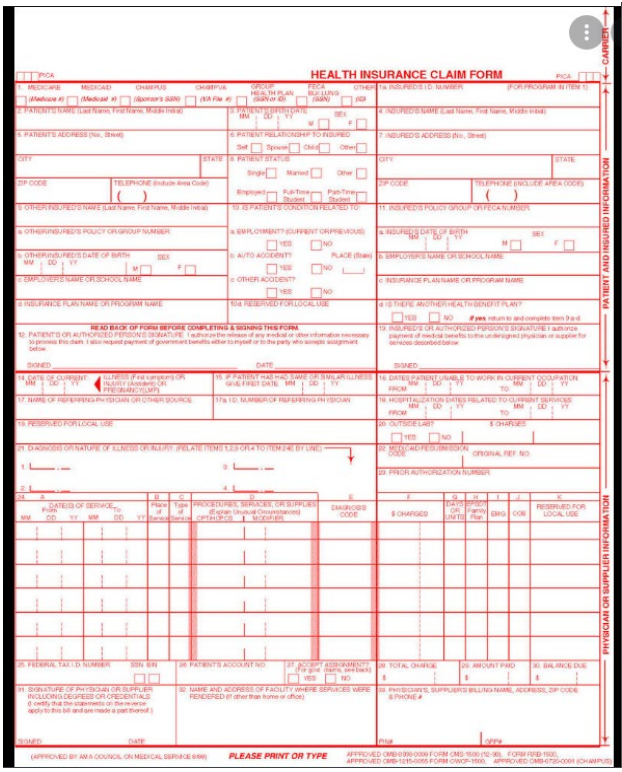
1. This policy provides coverage on a secondary/excess basis and if you have any other primary insurance coverage you will need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your 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, please contact Customer Service at (800) 328-1114. They are available from 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820 or email to claims@hsri.com.
You may also upload documents via our website at https://www.hsri.com/contact
Please allow up to 5 business days for documents to be loaded into our claims system.

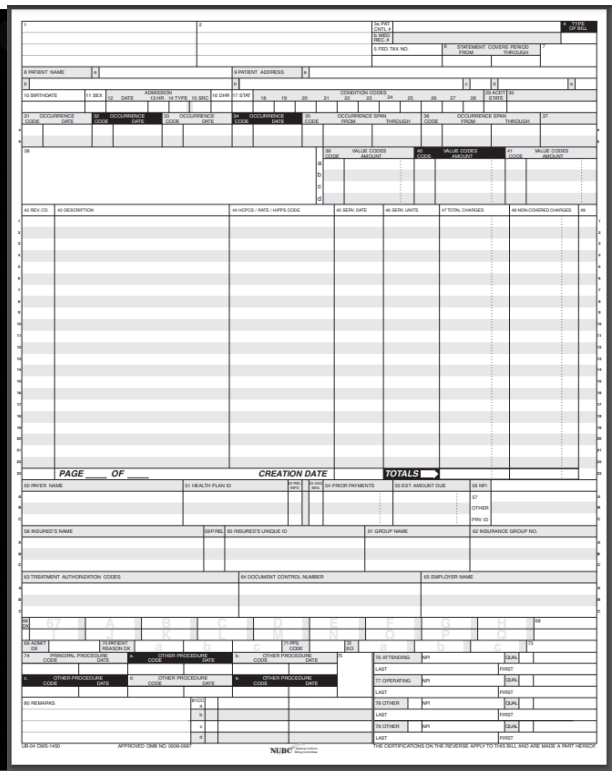
Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, Texas 75024

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 HCFA-1500 for physician services or UB04 for facility charges. See below examples.


HEALTH INSURANCE CLAIM FORM

PLEASE PRINT OR TYPE


PAGE ___ OF ___ CREATION DATE TOTALS

Sample CMS HCFA Billing ***Sample UB04 Billing***