You've Been Injured ... Now What ??

At NAHGA Claim Services, our job is to help you through the process of filing your medical claims. Below is a brief description of the necessary steps you must now take:

- Complete claim reporting form/incident report – Mail to the address listed on the form
- Whenever possible, share that mailing address with your medical providers.
- If you have any other insurance, please have all medical bills filed to that other insurance ***first***.
- Lastly, submit a copy of each itemized medical bill (including procedure and diagnosis codes), along with a copy of your primary insurance Explanation of Benefits (EOB), if you have other insurance.

Payments are made by NAHGA directly to the medical providers unless a payment receipt is submitted at the time of the bill.

Please contact NAHGA Claim Services at (800) 952-4320 or claims@nahga.com
or fax (207)647-4569 if we may be of assistance during this process.

Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:

Underwritten by:
Chubb Insurance

NAHGA Claim Services
PO Box 189
Bridgton, Maine 04009
(800) 952-4320
(207) 647-4569 Fax
claims@nahgaclaims.com

IMPORTANT NOTICE:
This insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

If this form is not completed in FULL, this claim can not be processed and will be returned.

PART 1: INCIDENT REPORT

(1) School/Organization/Group Name G.U.A.R.D Trust 9907-0123 / 0124		(2) Name of Sport Team/Location	
(3) Claimant - Last Name, First Name		(4) Claimant Social Security Number (if available)	
(5) Mailing Address where Insurance Info/Requests should be mailed		(6) City, State, Zip	
(7) Birthdate	(8) Male ❑ Female ❑	(9) Phone	(10) Email (if available)

INJURY - Please Complete this Section to report an Injury

(11) Date of Injury	(12) Time & Address where occurred?	(13) Part of body injured
(14) How did injury occur (description of incident)?		(15) Date of first medical treatment
(16) Sport Type (i.e. Football, Basketball, etc.)	(17) If injury was sport related, please indicate which sport?	

(18) Action Taken: ❑ Released to Parent (minor) ❑ Ambulance Transport ❑ Referred to Hospital/Clinic ❑ Own Accord (Adult) ❑ Other _____

(19) Was the claimant supervised when injured? Yes ❑ No ❑	(20) Was injury during travel to or from scheduled activity in a supervised group? Yes ❑ No ❑

(21) Signature of Director: Date

PART 2: PARENT OR GUARDIAN STATEMENT (Must be completed if claimant is a minor)

(1) Father/Guardian Name Telephone	(2) Mother/Guardian Name Telephone
(3) Home Address (Street, City, State, Zip)	(4) Home Address (Street, City, State, Zip)
(5) Employer	(6) Employer
(7) Father's Employer Address (Street, City, State, Zip)	(8) Mother's Employer Address (Street, City, State, Zip)
(9) Business Phone	(10) Business Phone
(11) Employer Medical Insurance Policy (11a) Is Claimant covered under that policy? Yes ❑ No ❑	(12) Employer Medical Insurance Policy (12a) Is Claimant covered under that policy? Yes ❑ No ❑

PART 3: INSURANCE VERIFICATION

Is Claimant covered by any other insurance policy (other than this policy), either as a dependent, group, individual, automobile medical or liability? Yes ❑ No ❑

If yes, please list name of insurance carrier: _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.

PART 4: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Claimant to disclose when requested to do so, any information to NAHGA CLAIM SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.

X _____ _____

Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____ _____

Signature of Claimant (or Parent/Guardian if Claimant is under 18 years of age) Date

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Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill.