



- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
- 3. MAIL TO HEALTH SPECIAL RISK, INC.

# HSR

Health Special Risk, Inc.

HSR Plaza  
 4001 North Josey Lane  
 Carrollton, TX 75007-1520  
 866-726-8870  
 Fax 972-492-4946

To be completed by BSA Leader  
 Council Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**PART 1 - BSA Leader's Statement ACE American Insurance Company**

Check One:  Tiger Cub  Tiger-Cub Adult  Varsity Scout  Cub  Scout  Venturer  Leader  Committee  
 Learning for Life - Explorer  Seasonal Staff  Other \_\_\_\_\_

Check Policy:  Council  Unit  Campers & Special Events  National Events

Post Number \_\_\_\_\_ Team Number \_\_\_\_\_ Troop Number \_\_\_\_\_ Pack Number \_\_\_\_\_

1. Name of Insured (Claimant) \_\_\_\_\_ 2. Social Security Number \_\_\_\_\_ 3. Sex  F  M 4. Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Address of Insured Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

6. Parent's name, address and telephone number (include area code) \_\_\_\_\_

7. What date did accident happen or sickness begin? \_\_\_\_\_ 8. Nature of injury or sickness (indicate part of body injured - such as broken arm, sprained ankle, etc.) \_\_\_\_\_

9. Describe how accident occurred - give details \_\_\_\_\_

**FOR DENTAL CLAIMS ONLY** 10. Indicate which teeth were involved in the accident \_\_\_\_\_ 11. Describe condition of injured teeth prior to accident:  
 Whole, sound and natural  Filled  Capped  Artificial

12. Name of event or activity \_\_\_\_\_ 13. Name and title of supervisor \_\_\_\_\_

14. Signature of policyholder representative \_\_\_\_\_ X \_\_\_\_\_ 15. Title \_\_\_\_\_ 16. Date \_\_\_\_\_

**PART 2 - Other Insurance Statement**

Do you/spouse/parent have medical/health care coverage through your employer or other source on you?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:  
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:  
 Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**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.

Signature of participant or parent \_\_\_\_\_ X \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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.**

**Authorization to pay benefits to provider**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization for release of information**

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 photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS**

## HOW TO SUBMIT A CLAIM

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You have been injured and you need to file a claim for consideration of benefits. How is that done? Below are basic items that need to be included in order to have your claim considered. Please keep in mind that we are not guaranteeing your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.

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There are three basic items that are required in order for a claim to be considered eligible for benefits.

1) **A Completed Claim Form**

Please be sure to neatly and fully complete your claim form. If you do not have a claim form, please call **HSR** for assistance. Your claim form must have a policyholder's authorized signature. The policyholder representative is an employee or other administrator that acts on behalf of the policyholder to verify your claim. The policyholder will typically be your BSA or LFL Leader.

2) **Copies of Fully Itemized Bills**

Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-92 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis code. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

3) **Copies of Your Primary Insurance's Explanations of Benefits**

**The policy is excess to any other available source of medical benefits if the charges are greater than \$300.00.** This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding. **If the total charges are less than \$300.00, we will pay without the other insurance coordination.** When your primary insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

***IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Part 2 of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You MUST sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document.***

For specific policy information, please call **HSR** to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has limitations on claim submission as well as on the benefit period, which is the period of time for which benefits are available for treatment for that injury from the date of injury. Treatment received past the benefit period is not eligible for benefits.

### CONTACT INFORMATION

**Health Special Risk, Inc.**  
4001 North Josey Lane  
Carrollton, TX 75007  
Toll Free Number 1-866-726-8870  
Fax Number: 972-492-4946  
Customer Service Email: [claims@hsri.com](mailto:claims@hsri.com)