

# PROOF OF LOSS

## Specialty Risk International, Inc.

303 Congressional Boulevard  
Carmel, IN 46032  
800-335-0477 or 317-575-2656 Fax: 317-575-2256

Insurance Carrier: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

### ACCIDENT AND ILLNESS CLAIM FORM

#### Instructions:

- 1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
- 2.) Section A must be completed by the Insured in full.
- 3.) One of the following must be provided:
  - A.) Section B fully completed by the Attending Physician, or B.) Fully itemized bills including: Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
- 4.) This form must be signed and dated in all applicable sections.
- 5.) This form and all attached bills must be submitted to the address indicated above.

**The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.**

#### SECTION A

Coverage Effective Date \_\_\_/\_\_\_/\_\_\_ Coverage Termination Date \_\_\_/\_\_\_/\_\_\_

- 1.) Name of Insured: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ Male \_\_\_ Female
- 2.) Name of Claimant: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ Male \_\_\_ Female
- 3.) Current Residence Address: \_\_\_\_\_  
Date of Arrival in U.S.: \_\_\_/\_\_\_/\_\_\_ Daytime Phone Number: (\_\_\_\_\_) \_\_\_\_\_
- 4.) Permanent Address (In Home Country): \_\_\_\_\_  
Date scheduled to return to Home Country: \_\_\_/\_\_\_/\_\_\_
- 5.) If Accident, provide details, i.e., how when and where accident occurred: \_\_\_\_\_  
\_\_\_\_\_
- 6.) If Illness, advise when and where symptoms first occurred and nature of illness: \_\_\_\_\_  
\_\_\_\_\_
- 7.) Name and address of Consulting Physicians: \_\_\_\_\_  
\_\_\_\_\_
- 8.) Have you ever been treated for this illness before? Yes\_\_\_ No\_\_\_ If Yes, when? \_\_\_\_\_
- 9.) Provide Name and Address of your Regular Physician in your Home Country: \_\_\_\_\_  
\_\_\_\_\_
- 10.) Please advise names of any prescription medications you are presently taking: \_\_\_\_\_  
\_\_\_\_\_
- 11.) Indicate other Health Insurance coverage, include name, address, policy number and certificate number of Insurer: \_\_\_\_\_  
\_\_\_\_\_

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator furnish to the Claims Administrator named above or its representatives, any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrators to provide the Claims Administrator named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

\_\_\_\_\_  
Signature of Claimant or Parent, If Claimant is a Minor

\_\_\_\_\_  
Date

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Section B

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMP <input type="checkbox"/> VA GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>								1a. INSURED'S I.D. NUMBER				
2. PATIENT'S NAME (First Name, Middle Initial, Last Name)				3. PATIENT'S DATE OF BIRTH MM DD YY / /		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (First Name, Middle Initial, Last Name)				
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)			7. INSURED'S ADDRESS (No., Street)					
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				CITY		STATE		
ZIP		TELEPHONE NUMBER ( ) ( ) ( ) ( ) ( ) ( )				ZIP		TELEPHONE NUMBER ( ) ( ) ( ) ( ) ( ) ( )				
9. OTHER INSURED'S NAME				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				
A. OTHER INSURED'S POLICY OR GROUP NUMBER				A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				A. PATIENT'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		
B. OTHER INSURED'S DATE OF BIRTH MM DD YY				B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				B. EMPLOYER'S NAME OR SCHOOL NAME				
C. EMPLOYER'S NAME OR SCHOOL NAME				C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				C. INSURANCE PLAN NAME OR PROGRAM NAME				
D. INSURANCE PLAN NAME OR PROGRAM NAME				D. RESERVED FOR LOCAL USE				D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return & complete item 9 A-D				
12. PATIENT'S OR AUTHORIZED PERSONS' 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.  Signature: _____ Date: _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to undersigned physician or supplier for services described below.  Signature: _____ Date: _____						
14. DATE OF CURRENT MM DD YY / /			ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY / /			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM: / / TO: / /			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM: / / TO: / /			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  1. _____ 2. _____ 3. _____ 4. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER			
24. A		B	C	D		E	F	G	H	I	J	K
DATES OF SERVICES FROM TO MM/DD/YY MM/DD/YY		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
/ /												
/ /												
/ /												
/ /												
/ /												
/ /												
25. FEDERAL TAX I.D. NUMBER SSN <input type="checkbox"/> EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGES \$		29. AMOUNT PAID \$		30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof)  Signed: _____ Date: _____						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).			33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE#  PIN # _____ GRP# _____			

PLACE OF SERVICE CODES  
 1-(H) - INPATIENT HOSPITAL  
 2-(OH)-OUTPATIENT HOSPITAL  
 3-(O)-DOCTOR'S OFFICE  
 4-(H)-PATIENT'S HOME  
 5-DAYCARE FACILITY (PSY)  
 6-NIGHT CARE FACILITY( PSY)  
 7-(NH) NURSING HOME  
 8-(SNF)-SKILLED NURSING FACILITY  
 9-AMBULANCE  
 O-(OL)-OTHER LOCATIONS  
 A-(IL)-INDEPENDENT LABORATORY  
 B-OTHER