



# NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for **accident medical claims**.  
**Claims must be filed within 90 days of injury and contain a valid social security number and/or visa number before processing can begin.**

### Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. This form must be filed within 90 days of injury. After the primary insurance has paid benefits, you must submit copies of all the EOB's (explanation of benefits) from the primary insurance. Only then will this insurance begin adjudication and pay benefits if available.

### Deductible (\$200)

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

### Claim Form

This company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

### Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital. Notify all medical providers – hospitals and doctors – that you will be using this insurance. You may provide them with the name and mailing address requesting they submit the required billing forms to Loomis.

### Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

### Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is sent.

- If the injured person has primary health insurance has the claim been submitted first to the primary?* \_\_\_\_\_
- If claim has first been submitted to the primary, are copies of the EOB's (explanation of benefits attached?* \_\_\_\_\_
- Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* \_\_\_\_\_
- Is part (B) of the claim form completed by the injured person and signed?* \_\_\_\_\_
- Are the attached medical bills itemized in either a CMS 1500 or UB04 form?* \_\_\_\_\_
- Is part (B), item number 3, (social security number and/or visa number) completed?* \_\_\_\_\_

**Mailing the Claim**

When completed in full, mail the attached completed form, itemized medical bills and copies of the EOB's (explanation of benefits, for use if coverage is excess) to:

The Loomis Company  
AYSO Accident Claims  
P O Box 13906  
Reading, PA 19612-4085

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 410-1089.

Documents may also be faxed to the claims office at (610) 373-9707. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

**PLEASE NOTE, Parts A & B of this claim form should be submitted WITHIN 90 days of the first day of the injury. This form may be filed prior to receiving all Primary EOBs and itemized medical bills.**

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**ACCIDENT DEDUCTIBLE CREDIT SHEET**

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Injured's Name : \_\_\_\_\_

Policyholder's Name : \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Name & Address check should be sent to:

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

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

*If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your request, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.*



**PART B** - This part **MUST** be **completed, dated** and **signed** by the Injured Person - or if the Injured Person is under age 18 or otherwise dependent - by his/her Parent or Guardian.

**PRINT HERE:** Name of person completing form: \_\_\_\_\_ **Check One:**  Injured Person  
 Parent  
 Guardian

**AMERICAN YOUTH SOCCER ORGANIZATION** **Policy Number: BAP-102264-1**

**Give the following information about the Injured Person:**

<b>1. Date of Birth</b> Mo Day Year / /	<b>2. Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>3. Social Security # or Student Visa #</b> SS# / / visa#	<b>4. Area Code/Phone #</b> ( )
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**5. Address** (Street) (City) (State) (Zip)

**6. Employer** (Street) (City) (State) (Zip)

Employer Phone # ( )

**7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ? No ?**

If YES, provide the following information: Name of Policyholder(s):

Name of Other Insurance Company Address: Policy #:

**8. If the Injured Person is under 18 or otherwise dependent, give the following information:**

Name of Father or Male Guardian Social Security #  
/ /

Place of Employment: Address: Employer Phone #  
( )

Name of Mother or Female Guardian Social Security #  
/ /

Place of Employment: Address: Employer Phone #  
( )

**9. If the Injured Person is married, give the following information:**

Name of Spouse: Social Security #  
/ /

Place of Employment: Address: Employer Phone #  
( )

I hereby authorize my physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Starr Indemnity and Liability Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

**Check One:**  Injured Person  
 Parent  
 Guardian

X  
 \_\_\_\_\_  
*Signature (in writing) of Responsible Party*

\_\_\_\_\_  
*Print Name* Date: \_\_\_\_\_