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

2023-2024

CHUBB

PRINT

CLEAR

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

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.

PART 1: POLICYHOLDER & INSURED

(1) Organization/Group Name Diocese of Dallas	(2) Policy Number 9907-6001
(3) Claimant - Last Name, First Name	(4) Claimant Social Security Number
(5) Mailing Address where Insurance Info/Requests should be mailed	(6) City, State, Zip
(7) Birthdate / (8) Male ◯ Female ◯	(9) Phone & Email

INJURY - Please Complete this Section to report an Injury

(10) Date of Injury	(11) Where did injury occur?	(12) Part of body injured

(13) How did injury occur (description of incident)?	(14) Date of first medical treatment
(15) Type of Sport (if applicable)	(16) Sport Designation: Practice ◯ Game ◯ Club ◯ Other ◯ _____

(17) Action Taken: ◯ Released to Parent ◯ Ambulance Transport ◯ Referred to MD/Clinic ◯ Own Accord (Adult) ◯ Other _____

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

(20) Name PRINT and Signature of Supervisor/Coach:	(21) School Name:	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 photostatic 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.

2023-2024

Excess Accident Medical Expense

Student's family medical insurance is primary and has to be filed first. An E.O.B. from the primary carrier has to be provided to NAHGA if filing an excess claim.

1. **Complete all items on the attached claim form.**

2. **Attach the following documents:**

   - **Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.**
   - **Copies of the Explanation of Benefits from your primary insurance carrier**

3. **Send the completed and <u>signed</u> claim form and all required documents to:**

NAHGA, INC.
POB 189
Bridgton, Maine 04009
Phone# 800-952-4320
Fax# 207-647-4569

4. **Retain a copy for your records.**

This insurance plan is excess insurance and is designed to provide maximum benefits at minimum cost and is secondary to all other insurance you may have. Please submit all expenses to your primary insurance first. Once that claim has been processed, please include their Explanation of Benefits when submitting your claim for benefits under this policy.

Attention Medicare and Medicaid Enrollees: This insurance is primary to your Medicare or Medicaid coverage. If you wish payment to be made to you, you must provide proof of payment from the provider.

YOU WILL BE CONTACTED BY NAHGA, INC.
IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE
CALL NAHGA, INC.AT 800-952-4320
Reference Company Name - The Diocese of Dallas and Policy Number
9907-6001