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MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com

BOTH SIDES OF CLAIM FORM MUST BE COMPLETED AND RETURNED WITH ITEMIZED BILLS WITHIN 30 DAYS.

EDI PAYOR ID# 22384

-PLEASE PRINT ALL INFORMATION-

PARTS I & II MUST BE COMPLETED AND SIGNED BY STUDENT

Name of Group, City and State | Graduate ☐ Undergraduate ☐ Domestic ☐ International ☐ | Policy Number | Birth Date

Insured Member's Name _____ (LAST NAME / FIRST NAME / MIDDLE INITIAL) | _____ (MEMBER ID#) | _____ (PHONE #)

Present Address _____ (NO. AND STREET / CITY OR TOWN / STATE / ZIP CODE + 4)

Home Address _____ (NO. AND STREET / CITY OR TOWN / STATE / ZIP CODE + 4 / NAME OF HOME COUNTRY)

If claim for dependent, give dependent's name _____ relationship to Insured _____ Age _____

***Do you hold a J-1 Visa ?_____ If yes, please attach a copy of your DS-2019 form from the university.**

COMPLETE THIS SECTION FOR ACCIDENT CLAIM	COMPLETE THIS SECTION FOR SICKNESS CLAIM
Nature of Injury (Describe fully, including which part of body was injured.) _____	Date of Sickness
Describe How, When and Where Accident Occurred (Include Date and Time) _____	Date symptoms first noticed _____ What is the exact nature of the sickness _____
Was the injury due to the practice or play of an Intercollegiate or Club sport? ☐ Yes ☐ No If yes, please indicate the Sport: _____ Signature of College Official: _____	If pregnancy, date of last menstrual period _____ Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, date of first treatment _____
Is condition work related? ☐ Yes ☐ No Is condition due to auto accident? ☐ Yes ☐ No If yes, please attach detailed policy information on all motor vehicles involved in accident.	Date of last treatment _____
Were you treated in the Student Health Center for this condition? ☐ Yes ☐ No Seen by: _____ Date: _____ If your claim is for services outside of the Student Health Center, were you referred? ☐ Yes ☐ No If not, why? Away from school For what reason: _____	Were you treated in the Student Health Center for this condition? ☐ Yes ☐ No Seen by: _____ Date: _____ If your claim is for services outside of the Student Health Center, were you referred? ☐ Yes ☐ No If not, why? Away from school For what reason: _____

Administrative Concepts, Inc. does not share private health information except as required or permitted by law.
We are committed to guarding the private information entrusted to us.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT THE TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____ (STREET / CITY / STATE / ZIP CODE + 4)

PART II

Please Print All Information

Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months? ☐ Yes ☐ No

If yes, indicate the name and address of the company _____

Effective date of coverage: _____ Expiration date: _____ Policy No. _____

Have you filed a claim with any other insurance company? ☐ Yes ☐ No

I hereby certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

or Legal Designation _____

The following section is applicable if you are covered under any other medical insurance plan.

Mother's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Father's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

Spouse's Name _____ Employer's Telephone # _____ Policy No. _____

Employer's Name and Address _____

Name and Address of Insurance Co. _____

The laws of some states require us to furnish you with the following notices:

WARNING – Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

For AL residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
For CA residents: Warning – Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
For FL residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
For KS residents: WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud as determined by a court of law, which is a crime and subjects the person to civil and criminal penalties.
For KY residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
For LA residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
For ME residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."
For NJ residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
For NM residents: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
For NC resident: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and may subject the person to civil and criminal penalties.
For OH residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."
For OK residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."
For OR residents: WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.
For PA residents: Any person who knowingly and with intent to defraud 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.
For RI residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
For TN residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
For VA residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."
For VT residents: WARNING - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may commit insurance fraud, which may be a crime and may subject the person to civil and criminal penalties.