Florida Annual Conference
United Methodist Church
Risk Management Program

2005 Accident Medical Claim Form

(For Volunteer, Nursery, Pre-K and Daycare Injuries)

Please mail completed Claim Form with itemized bills and receipts to:

To expedite your claim, please complete sections A, B, C & D and fax it to: (302) 476-6154

ACE USA
1 Beaver Valley Road
PO Box 15417
Wilmington, DE 19850
(800) 262-8028 or (302) 476-6154

Complete a separate Claim Form for each individual.

SECTION A. PATIENT INFORMATION

Sponsoring Organization: **Florida Annual Conference United Methodist Church** Policy#: **PTPN00174543**

Church Name: ________________________________ City______________________ GCFA#_______________

Patient's Name ________________________________ Patient's Date of Birth ___________________

Home Address ____

Please provide telephone and facsimile numbers, with area code.

Home #____________________ Work # _______________ Fax #________________ E-mail_______________

Supervisor's Name ____________ Work #________________ Fax # _______________ E-mail________________

SECTION B. ACCIDENT INFORMATION *Please complete this section*

Date/Time: ____

Place: ____

Participating Activity: ____

Detail of Accident: ____ ______

____

____

SECTION C. PAYMENT INFORMATION *Please complete either Option #1 or Option # 2*

☐ OPTION #1 (Payment to Patient) ***Please indicate where you wish the payment to be sent***

- ☐ Your home address as listed above
- ☐ Other: ____

☐ OPTION #2 (Payment to a Provider, e.g. hospital, physician)
Please complete Provider's name and address in Section E of this Claim Form

Payment Authorization: I authorize payment directly to me or to the healthcare provider in Section E of this Claim Form.

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information, which may be necessary to determine claim payment.

PATIENT'S SIGNATURE: ____ **DATE:**__________________

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SECTION D. OTHER COVERAGE INFORMATION

Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.

Do you have any other insurance? ☐Yes ☐ No If yes, please provide source of insurance.

Please indicate source ____

Is this claim accident related? ☐ Yes ☐ No Is this claim worked related? ☐Yes ☐ No

If yes, please provide documents relating to accident or work injury.

If claim is due to an accident, are you seeking reimbursement from another source? ☐ Yes ☐ No

Please indicate source ____

SECTION E. PHYSICIAN OR PROVIDER *Please complete this section.*

Name, address, and telephone # of physician or provider of service____

____

Diagnosis or nature of illness or injury ____

Date of illness (first symptom) or injury ____________________ Date first consulted for this condition ________________

Hospital confinement dates: From ____________ To __________ Date able to return to work ________________________

Total disability dates: From _________________ To __________ Partial disability dates: From__________ To _________

Patient's account # ____________________________________ Amount paid ____________ Balance due ____________

Place of service ____ Diagnosis code and description ____________________

Date of Service	Procedure code and description/ Predetermination of benefits	Charges	Total charges

WARNING: Any person who files a statement of claim containing any false, incomplete, or misleading information, who knowingly and with intent to injure, defraud, or deceive any insured, is guilty of a crime.