2560 River Park Plaza, Suite 300
Fort Worth, Texas 76116
(817) 738-6100 FAX (817) 738-2993
PullenIns.com

NEW HAMPSHIRE SOCCER ASSOCIATION
ACCIDENT MEDICAL CLAIM FORM

GUIDELINES FOR SUBMITTING A SOCCER ACCIDENT CLAIM FORM

1. Complete **ALL** questions on the Soccer Accident Claim Form.
2. Have the authorized official with your local organization sign **Section II** (LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in **Section V** (FRAUD STATEMENT).
4. File this claim form within 90 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have primary insurance, you must submit all charges to your primary carrier first. You will receive a Explanation of Benefit worksheet (EOB) from your other carrier. The EOBs may be attached to this claim form. Do not wait until your primary carrier has processed all of your bills before filing a Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to the New Hampshire Soccer Association for verification and the authorized state signature. **DO NOT SEND THE CLAIM FORM DIRECTLY TO PULLEN INSURANCE SERVICES, AS THIS WILL CAUSE A DELAY IN THE PROCESSING OF YOUR CLAIM**
8. Upon receipt of the claim form from New Hampshire Soccer Association, the insurer, Mutual of Omaha, will forward an acknowledgement letter confirming receipt of your claim. All future correspondence concerning your claim should be directed to Mutual of Omaha at the address and phone number listed on your acknowledgement letter.

HELPFUL REMINDERS

1. There is a $500 corridor deductible per covered accident for the 9/1/17 - 9/1/18 policy year and eligible charges will be paid per the policy terms. Each claim is also subject to the application of a $50 physical therapy/chiropractic limit per visit/$2,000 total maximum. Failure to follow the rules of your primary healthcare coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise payable.
2. Each itemized bill MUST show the following:
   - Provider of Service's Name
   - Provider's Address
   - Provider's Federal Tax ID#
   - Provider's Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-9)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure
3. Additional bills can be submitted at a later date (after the initial submission of your claim) and should be mailed directly to Mutual of Omaha at the address listed on your acknowledgement letter and include the following: Name of the claimant, policy number (T5MP-P-052850), claim number, and that you are a member of the New Hampshire Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Claimant's responsibility to request this information from the provider of service or from your primary insurance carrier.
6. An Explanation of Benefits will be sent to you by Mutual of Omaha.

MOST FREQUENTLY ASKED QUESTIONS

What is an itemized bill?

An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

What if I don't have an itemized bill?

The Claimant must request this information from the provider of service. Some providers only mail a balance due statement. The insurer is unable to process any charges without an itemized bill. Again, request this information from the provider service. Explain that you have excess / secondary accident medical coverage.

Can you process this claim with my other insurance carrier's worksheet alone?

No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

What if I don't have my other carrier's payment explanation (EOB)?

The Claimant must request the EOB from their other insurance carrier.

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IMPORTANT
This claim form must be mailed to your state association listed below:

New Hampshire Soccer Association
1600 Candia Road, Suite #3
Manchester, New Hampshire 03109

POLICYHOLDER: NEW HAMPSHIRE SOCCER ASSOCIATION

POLICY NUMBER: T5MP-P-052850

SECTION I TO BE COMPLETED BY CLAIMANT (PARENT OR GUARDIAN IF UNDER AGE 18)

1. Name: (LAST)_____(FIRST)_____(MIDDLE) _____
2. Date of birth: _____ / _____ / _____ 3. Sex: ☐ Male ☐ Female
4. Home Address: (STREET)_____

   (CITY) _____ (STATE) _____ (ZIP CODE) _____
5. Type of claimant: ☐ Player ☐ Coach/Asst Coach ☐ Other: _____
6. Accident date: _____ / _____ / _____
7. Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): _____

   _____
8. Did accident occur during (✓ all that apply) ☐ game ☐ practice ☐ tournament ☐ indoor soccer
   ☐ sanctioned/sponsored activities ☐ travel directly and interruptedly to or from activity premises
9. Describe how injury was sustained: _____

   _____
10. Name of field / facility where accident occurred: _____
11. Name of local league or club: _____
12. Name of team:_____
13. Name of witness (Coach, Manager or Referee) present at time of injury: _____
14. Phone # of above witness: _____

SECTION II LOCAL OFFICIAL VERIFICATION

Signature of Local Official	Local Official Name (print) and Title	Date

SECTION III AUTHORIZED STATE OFFICIAL *

I, _____, of the New Hampshire Soccer Association certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

*Signature of Authorized State Official	Title	Date

*** Must be signed by the authorized state soccer association administrator with the state soccer office.**

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CLAIMANT'S NAME: _____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

SECTION IV PARENT / GUARDIAN / CLAIMANT INFORMATION

Father / Guardian / Claimant	Mother / Guardian / Claimant
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Home Phone: (_____) _____ - _____	Home Phone: (_____) _____ - _____
Employer: _____	Employer: _____
Phone: (_____) _____ - _____ Ext. _____	Phone: (_____) _____ - _____ Ext. _____
Email: _____	Email: _____

Is claimant covered under ANY other insurance policy? ☐ Yes ☐ No

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Insured Name: _____

Insured ID #: _____ Insured Group # / Name: _____

If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party: _____

_____

SECTION V FRAUD STATEMENT – PLEASE READ THOROUGHLY

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent Date

SECTION VI IMPORTANT NOTICE

This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with our itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or Others) unless a paid receipt statement accompanies the bill at the time the claim is submitted.

Coverage Underwritten by: Mutual of Omaha