C. HOW TO FILE A MEDICAL CLAIM TO CO-ORDINATED BENEFIT PLANS

STEP #1

Submit a completed Notice of Claim (claim form) by mail, fax, or email to:

Co-ordinated Benefit Plans: P.O. Box 21282, Tampa, FL 33622
Phone: 877-477-4209 Fax: 800-561-8084
Email: GAICClaims@CBPInsure.COM

All claims forms are provided within this manual.

Please note: The Policyholder, Parent, Claimant or Authorized Representative should:

- ☐ Fully answer each item in Part A, Claimant's Notice of Accident.
- ☐ Authorized Representative must sign Part A.

The Parent/Guardian or Adult Claimant should:

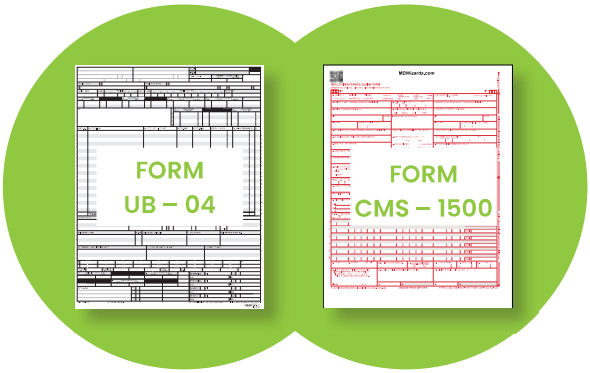
- ☐ Fully answer each item in Part B, including other insurance questions.
- ☐ Review authorizations and sign after reading the fraud warning notices on last page of claim form.

STEP #2

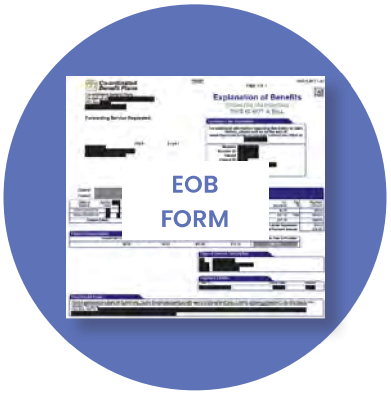
Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.



Provider
Provides to You



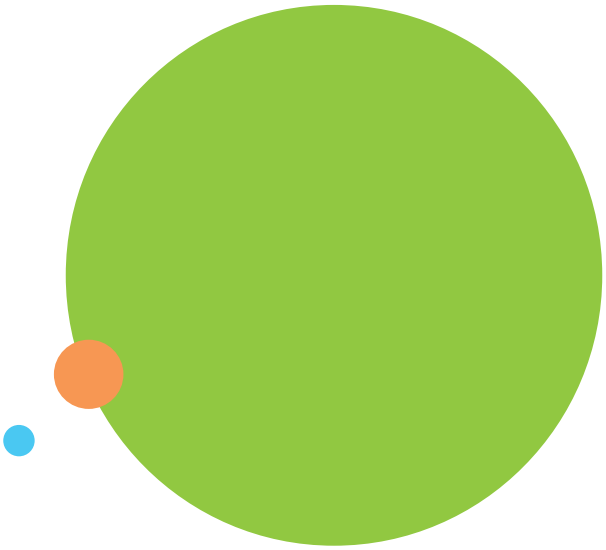
Primary Insurance Co.
Provides to You

- The acceptance of a claim form is not an admission or guarantee of coverage.
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges – examples below).
- Unless proof of payment is submitted with the medical bill claim payment is generally sent directly to the medical providers. Proof of payment includes a copy of the check, a medical bill that indicates the claimaint has made all of partial payment or zero balance information.

D. EXHIBITS-CLAIMS FORMS

Please note that you will find three separate claim forms for the various programs.

1. **BSR Claim Form –** (Pages 7 through 10 of this PDF) Used for groups such as: volunteers, camp programs, day cares, community, civic, church and nonprofit organizations.
2. **Supplemental Loss of Life Document –** (Page 11 of this PDF)



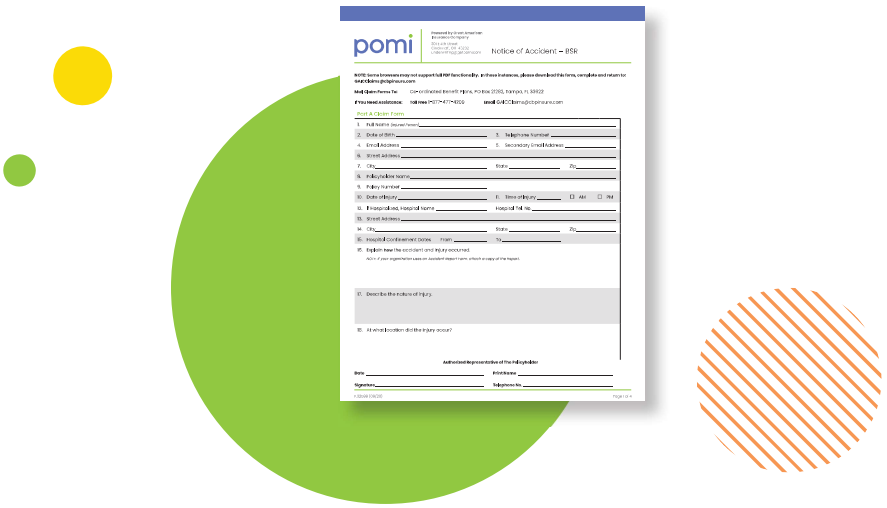
CLAIM FILING NOTICE-BSR

This claim form MUST be received by the Great American Insurance Company within 90* days of the date of injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52* weeks after the date of the accident.

*As otherwise noted in the Policy

CLAIM PROCEDURE

1. Have a Representative of the Policyholder complete, date and sign PART A.
2. The Injured Person (Insured) – or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – MUST complete, date and sign PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown above within 90 days of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) first, if applicable. This can include employee plans, union plans, service contracts, HMO Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment from your other health and accident insurance company(s), notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown above. You may also fax or email. Please see contact information shown above.



pomi

Powered by Great American Insurance Company
301 E 4th Street
Cincinnati, OH 45202
underwriting@getpomi.com

Notice of Accident – BSR

NOTE: Some browsers may not support full PDF functionality. In those instances, please download this form, complete and return to: GAICClaims@cbpinsure.com

Mail Claim Forms To: Co-ordinated Benefit Plans, PO Box 21282, Tampa, FL 33622

If You Need Assistance: **Toll Free** 1-877-477-4209 **Email** GAICClaims@cbpinsure.com

Part A Claim Form

1. Full Name *(Injured Person)* _____
2. Date of Birth _____ 3. Telephone Number _____
4. Email Address _____ 5. Secondary Email Address _____
6. Street Address _____
7. City _____ State _____ Zip _____
8. Policyholder Name Head Start of Lane County, Inc.
9. Policy Number BSR E917233 - 00
10. Date of Injury _____ 11. Time of Injury _____ ☐ AM ☐ PM
12. If Hospitalized, Hospital Name _____ Hospital Tel. No. _____
13. Street Address _____
14. City _____ State _____ Zip _____
15. Hospital Confinement Dates From _____ To _____
16. Explain **how** the accident and injury occurred.

    NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.

17. Describe the nature of injury.
18. At what location did the injury occur?

Authorized Representative of The Policyholder

Date _____ **Print Name** _____

Signature _____ **Telephone No.** _____

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

Give the following information about the Injured Person:

1. Date of Birth _____ 2. ☐ Male ☐ Female

3. Social Security No. _____ 4. Area Code/Telephone No. _____

5. **Employer *(if applicable)***

   Name _____

   Street Address _____

   City _____ State _____ Zip _____

   Area Code/Employer Telephone No. _____

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

   If yes, give the following information:

   Name of Other Insurance Company(s) _____

   Street Address _____

   City _____ State _____ Zip _____

   Area Code/Employer Telephone No. _____

   Policyholder Name _____

   Policy number _____

   Street Address _____

   City _____ State _____ Zip _____

   Social Security No. _____

   Relationship to Injured person _____ Area Code/Telephone No. _____

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

   Name of Spouse _____

   Social Security No. _____ Area Code/Telephone No. _____

8. Is the injured person eligible for Medicare/Medicaid? **Yes** ☐ **No** ☐

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, 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. The above information is true and complete to the best of my knowledge and belief.

I also authorize Great American Insurance Company or its agents or representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Great American Insurance Company from liability as to amounts so paid.

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 *(in FL, a felony in the third degree)*, and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature *(in writing)* of Responsible Party _____ **Print Name** _____

Check one: ☐ **Injured Person** ☐ **Parent** ☐ **Guardian** **Date** _____

SEE FOLLOWING PAGE FOR FRAUD WARNING NOTICES