



## How to File a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.  
Please forward claims and questions to the following address:

WebTPA  
P.O. Box 669  
Grapevine, TX 76099-0669  
Customer Service: (877) 563-7492  
Fax: (469) 417-1989

**Step 1: Submit a completed Notice of Claim (claim form) via either by mail or by facsimile.**

**The Participating Organization (not the Parent, Claimant or Agent) should:**

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

**The Parent/Guardian or Adult Claimant should:**

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the 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).**

### HOW TO FILE A CLAIM

**All information must be provided for a claim to be processed.**

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer all questions and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to address below:

**WebTPA**  
**P.O. Box 669**  
**Grapevine, Texas 76099-0669**  
**Customer Service: 877-563-7492**  
**Fax: 469-417-1989**

4. Advise all doctors / hospitals of this coverage so they may forward their itemized bills.
5. If you have already been to doctor / hospital and did not know about this coverage, send all itemized bills to address above.
6. Itemized bills should include name of doctor / hospital, complete mailing address, telephone number, date seen, what you were seen for (diagnosis) and specific itemized charges incurred. (Description of treatment including CPT codes and amount).
7. If you have other insurance, submit a claim to your other insurer. When an Explanation of Benefits is received from Primary Carrier, mail to address above along with all corresponding itemized bills and completed claim form. You must submit itemized bills which include:
  - a) HCFA-1500 (standard form used by Providers)
  - b) UB-04 or UB-92 (standard form used by Hospitals)
8. If you already paid the bill, include a paid receipt or copy of your cancelled check. Payment will be made to the Provider of Service unless a paid receipt statement accompanies the bill when claim form is submitted.
9. **Common Causes For Delays in Processing Claims**
  - a) Claim Form not fully completed or not submitted.
  - b) Balance Due, Balance Forward or Past Due statements submitted as itemized bills.
  - c) Explanation of Benefits from Primary Carrier not provided with itemized bills.

**Keep Copies of All Correspondence For Your Own Records Until Claim Has Been Processed.**



**PART I – PARTICIPATING ORGANIZATION STATEMENT**

Policy Number:		Policyholder / Organization Name:		Event, Activity or Sport:	
Name of School:		Street Address	City	State	Zip Code
Claimant's Name (Injured Person)		Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident		Place where Accident Occurred		The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other	
Dental Claims	Indicate which Teeth were Involved in the Accident		Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)				Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

- A. During a participating organization sponsored & supervised, or sanctioned activity?  YES  NO
- B. On activity premises?  YES  NO
- C. While traveling directly and uninterruptedly to or from the activity?  YES  NO
- D. During a participating organization practice?  YES  NO or competition?  YES  NO

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date
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**PART II – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source?  YES  NO

If Yes, name of insurance company:: \_\_\_\_\_ Policy #: \_\_\_\_\_

Mother's (Guardian's) primary employer name, address & telephone: \_\_\_\_\_

Father's (Guardian's) primary employer name, address & telephone: \_\_\_\_\_

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

YES  NO If yes, please explain: \_\_\_\_\_

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

**PART III – AUTHORIZATIONS**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



## FRAUD STATEMENTS

### Important Notice

- ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** 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 Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia: WARNING:*** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** 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 residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 residents of Maine, Tennessee, Virginia and Washington:*** 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 residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** 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 residents of New York:*** 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 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.
- ***For residents of Ohio:*** 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 residents of Oklahoma: 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 residents of Pennsylvania:*** 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.