AMERICORPSBENEFITS MEDICAL CLAIM FORM

BCS Insurance Company

PART A – CLAIM FORM INSTRUCTIONS

PLEASE PRINT

1. Read both sides of this form.
2. Completely fill out Sections B-F. (Part E is optional.)
3. Sign and date Section F.
4. Remember to provide your Social Security Number.

5. Attach all original itemized bills providing complete information on:
   - Doctor's Name and Address
   - Doctor's Tax Identification Number
   - Patient Name
   - Diagnosis Code ICD-9
   - Date of Service
   - Charges/Cost of each treatment
   - Procedure Codes CPT-4
   - Place of Service Code

Note: *Itemized bills are* ***NOT****:*
- Balance Due Statements
- Explanation of Benefits

6. If your medical provider sends your bill or claim to us, make sure an itemized bill is included.
7. Sign Section E if you want benefits paid to your medical provider.

8. If you have a Certificate of Creditable Coverage from your prior medical coverage, please attach it to your completed Medical Claim Form and send it to:

   ASRM, LLC
   505 South Lenola Road, Suite 231
   Moorestown, NJ 08057
   800-359-7475

9. Make a copy of this form for your records.

PART B – INSURED VOLUNTEER INFORMATION

INSURED VOLUNTEER'S NAME (LAST, first, middle) ☐ **Male** ☐ **Female**

DATE of BIRTH MM DD YY _____/_____/_____

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

PHONE NUMBER (☐☐☐) ☐☐☐-☐☐☐☐

ORGANIZATION NAME

ORGANIZATION GROUP NUMBER ☐☐☐☐☐☐☐☐

DOES THE INSURED VOLUNTEER HAVE OTHER HEALTH BENEFIT COVERAGE? ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE INSURANCE PLAN OR PROGRAM NAME, THE POLICY OR GROUP NUMBER, AND THE EFFECTIVE DATE:_____

PART C – CLAIM INFORMATION

IS THE CLAIM FOR AN: ☐ **ACCIDENT? OR** ☐ **ILLNESS?**

IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ **YES** ☐ **NO**

WHEN DID THE ACCIDENT OR ILLNESS OCCUR? MM DD YY _____/_____/_____

PLEASE EXPLAIN WHAT YOU WERE TREATED FOR AND, IF TREATMENT WAS THE RESULT OF AN ACCIDENT, PROVIDE DETAILS OF WHEN, WHERE AND HOW THE ACCIDENT HAPPENED. (If you need additional space, attach a sheet of paper to this form.)

HAVE YOU HAD PRIOR TREATMENT FOR THIS CONDITION? ☐ **YES** ☐ **NO**

IF YOUR ANSWER IS YES, WHAT WAS THE DATE OF TREATMENT? MM DD YY _____/_____/_____

PART D – PRESCRIPTION DRUG INFORMATION

	NAME OF CURRENT MEDICATION(S)	CONDITION BEING TREATED
1.		
2.		
3.		

IF YOU HAVE MORE THAN THREE CURRENT MEDICATIONS, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER AND INCLUDE THE ABOVE REQUIRED INFORMATION.

PART E – ASSIGNMENT OF BENEFITS

TO BE COMPLETED BY THE INSURED. DO NOT SIGN THIS SECTION IF FEES HAVE ALREADY BEEN PAID TO YOUR PROVIDER.
I APPROVE THE PAYMENT OF BENEFITS TO THE DOCTOR OR OTHER MEDICAL PROVIDER SHOWN ON THE ITEMIZED BILL (Tax Identification Number included). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNATURE OF INSURED VOLUNTEER

DATE MM DD YY _____/_____/_____

PART F – AUTHORIZATION

INSTRUCTIONS: **THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE INSURED VOLUNTEER. IF THE INSURED VOLUNTEER IS UNABLE TO SIGN, THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.**

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross-Blue Shield, self-insured and pre-paid health plans):

You are authorized to permit BCS Insurance Company, its Third Party Administrators, and its authorized representatives, to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition, including information relating to mental illness, drug or alcohol treatment, HIV (AIDS Virus), and disease of

_____
Print Name of Insured Volunteer

I understand the information obtained will only be used by BCS Insurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau, and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to BCS Insurance Company but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

SIGNED

DATE MM DD YY _____/_____/_____

RELATIONSHIP TO THE INSURED IF SIGNED BY OTHER THAN THE INSURED

IF SIGNED BY OTHER THAN THE INSURED, PLEASE PRINT NAME & ADDRESS AND INCLUDE GUARDIANSHIP PAPERS OR OTHER EVIDENCE OF LEGAL REPRESENTATION

SEND TO: ASRM, LLC ▪ 505 South Lenola Road, Suite 231 ▪ Moorestown, NJ 08057

NOTE: Incomplete forms and the absence of itemized bills may delay the processing of your claim.

FRAUD NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME ANY MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

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

California and Texas: 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.

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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of loss or benefit is a crime punishable by fines or imprisonment, or both.

New Hampshire: 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.