



- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS
- 3. MAIL TO HSR OR EMAIL

E-mail : [claims@hsri.com](mailto:claims@hsri.com)

**ACCIDENT INSURANCE SOLUTIONS**  
 Health Special Risk, Inc.  
 8400 Belleview Drive, Suite 150  
 Plano, Texas 75024  
 Payor ID# 65449  
 Phone (800) 328-1114 Fax: (972) 512-5820  
 Underwritten by: United States Fire Insurance Company

**Motorsports/Powerboat/PWC Claim Incident Reporting Form**

PART I - POLICYHOLDER'S REPORT		POLICY NUMBER:	
Name of Policyholder:		Address of Policyholder: Address, City, State, Zip)	
Name of Injured Person:		Injured: <input type="checkbox"/> Driver/Rider <input type="checkbox"/> Pit Crew <input type="checkbox"/> Official <input type="checkbox"/> Spectator <input type="checkbox"/> Other	
Address of Injured Person:			
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	SS# (Required for CMS Reporting):	
Best Contact Phone #:		E-Mail Address:	
Track Name / Location (if different from policyholder):			
Date of Injury:	Time of Injury:	Disposition: <input type="checkbox"/> On-Site Care Only <input type="checkbox"/> Refused Treatment <input type="checkbox"/> Ambulance to (City)	
Injured Body Part: Side of the Body: <input type="checkbox"/> Left <input type="checkbox"/> Right		Condition (sprain, fracture, concussion, etc.)	Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Benefits Claimed: <input type="checkbox"/> Accident-Medical		<input type="checkbox"/> Dental <input type="checkbox"/> Accidental Death Crum and Forster United States	<input type="checkbox"/> Specific Loss <input type="checkbox"/> Disability*
*If claiming for disability benefits, we need the name, address and a telephone number for your employer. Fire, Motorsports, Powerboat/PWC Claim Form			
Type: <input type="checkbox"/> Oval <input type="checkbox"/> Road Course <input type="checkbox"/> Drag Racing <input type="checkbox"/> Motorcycle		<input type="checkbox"/> Other	
Type of Event: <input type="checkbox"/> Boat <input type="checkbox"/> PWC <input type="checkbox"/> Other		<input type="checkbox"/> Event Class	
Occasion: <input type="checkbox"/> Pre-Race <input type="checkbox"/> Pit Stop		<input type="checkbox"/> During Race: <input type="checkbox"/> Start <input type="checkbox"/> Early <input type="checkbox"/> Mid <input type="checkbox"/> Late <input type="checkbox"/> Finish	
<input type="checkbox"/> After Race			
Description of Accident (Attach a Separate sheet if necessary):			
Witnesses: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, complete witness information below)			
Name / Address / Best Phone # of Witness:			
SIGNATURE OF WITNESS			
SIGNATURE OF POLICYHOLDER REPRESENTATIVE		TITLE	DATE

**PART II – STATEMENT OF CERTIFICATION (required)**

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: 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. (PURSUANT TO 11 NYC RR86)

Signature of Parent/Guardian/Claimant (required): \_\_\_\_\_ Date: \_\_\_\_\_

**By entering your name above in Part I and Part II, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.**

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**PART III – OTHER INSURANCE STATEMENT**

Do you/spouse/parent have medical/health care or is the Claimant 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 your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree?  YES  NO

If Yes: Name of Insurance Co:	Policy #
Name of Insurance Co:	Policy #

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.**

**Father/Guardian Name / Address / Best Phone #:**

**Mother/Guardian Name / Address / Best Phone #:**

**PART IV – AUTHORIZATION TO RELEASE INFORMATION TO PROVIDER**

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 Crum & Forster Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

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

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

- \*\* **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- \*\* **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
- \*\* **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- \*\* **Arkansas, Louisiana and Rhode Island:** 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.
- \*\* **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a 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.
- \*\* **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
- \*\* **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an 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.
- \*\* **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.

# Motorsports/Powerboat/PWC Claim Incident Reporting Form



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- \*\* **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
- \*\* **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
- \*\* **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.
- \*\* **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
- \*\* **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- \*\* **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- \*\* **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 of insurance fraud, as provided in RSA638:20.
- \*\* **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- \*\* **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 APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- \*\* **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.
- \*\* **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.
- \*\* **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.
- \*\* **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
- \*\* **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.
- \*\* **Texas:** Any person who knowingly presents a 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.
- \*\* **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Motorsports/Powerboat/PWC Claim  
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**HOW TO FILE A CLAIM**

Listed below are important instructions and comments about filing a claim.

**YOUR CLAIM FORM**

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim. **Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. The claim form must be signed by a policyholder representative.
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records, and mail to the address shown below.
5. DO NOT assume that anyone else will mail this claim form to **HSR** for you.

**YOUR BILLS**

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to **HSR** at the address shown below.
3. **The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.**
4. Due to HIPAA Privacy laws **HSR** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim. **HSR** cannot pay your bills using only the Primary Insurance Carrier’s EOB.

**EXCESS INSURANCE**

1. If this policy provides coverage on a secondary/excess basis and you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why. **HSR** will not be able to consider your claim without this information

If you have any questions, please contact Customer Service at (800) 328-1114. They are available from 8:00 a.m. to 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820 or email to [claims@hsri.com](mailto:claims@hsri.com).

***Health Special Risk, Inc.***  
**8400 Belleview Drive, Suite 150**  
**Plano, Texas 75024**

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## What is an Itemized Bill?

An itemized bill is a full detailed listing of all actual charges that a patient or their primary insurance is being billed for based on the care received. Typically, these come in the form of a HCFA-1500 for physician services or UB04 for facility charges.

See below examples.

**Sample CMS HCFA Billing**

**Sample UB04 Billing**

The image shows a sample CMS HCFA-1500 form. It is a complex form with multiple sections for patient information, insurance details, and medical services. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes fields for patient name, address, date of birth, and insurance policy information. It also contains a large table for medical services with columns for procedure codes, dates, and charges. The form is marked with red lines and includes instructions for completion.

The image shows a sample UB04 Billing form. It is a form used for facility charges and includes fields for patient name, address, date of birth, and insurance information. The form features a large table for medical services with columns for procedure codes, dates, and charges. It also includes a section for patient and insured information and a section for physician and supplier information. The form is marked with red lines and includes instructions for completion.

**Sample CMS HCFA Billing**

**Sample UB04 Billing**