



1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
(UB04 or HCFA-1500 Form)
 3. MAIL TO HSR
- E-mail : claims@hsri.com



8400 Bellevue Drive, Suite 150
Plano, Texas 75024
Payor ID# 65449
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (800) 328-1114
Underwritten by Everest Reinsurance Company

Group Name: _____

Policy Number: _____

Location of
Group/Club/Sport/School/etc.: _____

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person)		2. Social Security Number		3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)						
7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)						
8. Date and Time of Accident or Illness			9. Place where Accident or Illness Occurred			
Dental Claims	10. Indicate which Teeth were Involved in the Accident		11. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial			
12. Type of Injury (Indicate Part of Body Injured – e.g., (broken arm, sprained ankle, etc.)			Did Injury Result in Death? ☐ YES ☐ NO			
13. Describe How Accident Occurred – Give All Possible Details						
14. Did Accident Occur (Check Yes or No for Each of the Following):						
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?			☐ YES ☐ NO			
B. On activity premises?			☐ YES ☐ NO			
C. While on the job (if applicable)?			☐ YES ☐ NO			
D. While traveling to or from a regularly scheduled activity in a supervised group?			☐ YES ☐ NO			
E. During programmed hours?			☐ YES ☐ NO			
15. Name of Activity and Name of Sport (if applicable)			16. Name and Title of Supervisor			
17. Name of Policyholder						
18. Signature of Policyholder Representative			19. Title of Policyholder Representative		20. Date	

PART II – 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 company _____ Policy # _____
Name of insurance company _____ Policy # _____
Claimant's primary employer name, address, and phone number _____
Mother's primary employer name, address, and phone number _____
Father's primary employer name, address, and phone number _____

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

IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

New York Fraud Warning Notice: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material 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

SIGNATURE OF PARTICIPANT OR PARENT	DATE
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PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (if not signed, submit proof of payment)

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined 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. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

By entering your name above in Part II and Part III, 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.

FRAUD WARNING NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of 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.

STATE SPECIFIC PROVISIONS

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	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 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware Idaho	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, 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.
Florida	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 of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
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 a 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.
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 denial of insurance benefits.
Maryland	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 is guilty of a crime and may be subject to fines and confinement in prison.
Michigan North Dakota South Dakota	Any person who knowingly and with intent to defraud any insurance company or another person, files a 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 subject the person to criminal civil penalties.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
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 includes any false or misleading information on an application for an insurance policy 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 an 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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person 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.
Rhode Island 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.
Tennessee Virginia 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.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

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.
 1. **Please note that an itemized bill is defined as a bill/claim form from the provider via a UB04 or HCFA-1500 claim form. Submitting itemized bills in any other format will delay the claims process. Providers are familiar with this process, so please be sure to (1) contact the provider and share the details above and request that the provider submit outstanding balances directly to **HSR**; or (2) secure a copy of the UB04 or HCFA 1500s provided to the primary insurer and submit a copy to **HSR** for consideration. (See attached examples of a UB04 or HCFA-1500 on next page.)**
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 the 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.

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

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.

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA OTHER HEALTH PLAN (See Instructions) 2. INSURED'S ID NUMBER (For Program in Item 1)

3. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. PATIENT'S ADDRESS (No. Street) 5. CITY 6. STATE 7. ZIP CODE

8. PATIENT'S DATE OF BIRTH 9. PATIENT'S SEX 10. PATIENT'S RELATIONSHIP TO INSURED 11. INSURED'S ADDRESS (No. Street) 12. CITY 13. STATE 14. ZIP CODE

15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 16. OTHER INSURED'S POLICY OR GROUP NUMBER 17. OTHER INSURED'S DATE OF BIRTH 18. OTHER INSURED'S SEX 19. EMPLOYER'S NAME OR SCHOOL NAME 20. INSURANCE PLAN NAME OR PROGRAM NAME

21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 22. DATE 23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 24. DATE

25. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 26. DATE OF REFERRAL 27. NAME OF PHYSICIAN OR OTHER SOURCE 28. DATE OF REFERRAL

29. DATE OF SERVICE 30. PLACE OF SERVICE 31. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) 32. CHARGES 33. TOTAL CHARGE 34. AMOUNT PAID 35. BALANCE DUE

36. SIGNATURE OF PHYSICIAN OR SUPPLIER 37. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 38. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #

39. SIGNATURE OF PHYSICIAN OR SUPPLIER 40. DATE

41. SIGNATURE OF PHYSICIAN OR SUPPLIER 42. DATE

43. SIGNATURE OF PHYSICIAN OR SUPPLIER 44. DATE

45. SIGNATURE OF PHYSICIAN OR SUPPLIER 46. DATE

47. SIGNATURE OF PHYSICIAN OR SUPPLIER 48. DATE

49. SIGNATURE OF PHYSICIAN OR SUPPLIER 50. DATE

51. SIGNATURE OF PHYSICIAN OR SUPPLIER 52. DATE

53. SIGNATURE OF PHYSICIAN OR SUPPLIER 54. DATE

55. SIGNATURE OF PHYSICIAN OR SUPPLIER 56. DATE

57. SIGNATURE OF PHYSICIAN OR SUPPLIER 58. DATE

59. SIGNATURE OF PHYSICIAN OR SUPPLIER 60. DATE

61. SIGNATURE OF PHYSICIAN OR SUPPLIER 62. DATE

63. SIGNATURE OF PHYSICIAN OR SUPPLIER 64. DATE

65. SIGNATURE OF PHYSICIAN OR SUPPLIER 66. DATE

67. SIGNATURE OF PHYSICIAN OR SUPPLIER 68. DATE

69. SIGNATURE OF PHYSICIAN OR SUPPLIER 70. DATE

71. SIGNATURE OF PHYSICIAN OR SUPPLIER 72. DATE

73. SIGNATURE OF PHYSICIAN OR SUPPLIER 74. DATE

75. SIGNATURE OF PHYSICIAN OR SUPPLIER 76. DATE

77. SIGNATURE OF PHYSICIAN OR SUPPLIER 78. DATE

79. SIGNATURE OF PHYSICIAN OR SUPPLIER 80. DATE

81. SIGNATURE OF PHYSICIAN OR SUPPLIER 82. DATE

83. SIGNATURE OF PHYSICIAN OR SUPPLIER 84. DATE

85. SIGNATURE OF PHYSICIAN OR SUPPLIER 86. DATE

87. SIGNATURE OF PHYSICIAN OR SUPPLIER 88. DATE

89. SIGNATURE OF PHYSICIAN OR SUPPLIER 90. DATE

91. SIGNATURE OF PHYSICIAN OR SUPPLIER 92. DATE

93. SIGNATURE OF PHYSICIAN OR SUPPLIER 94. DATE

95. SIGNATURE OF PHYSICIAN OR SUPPLIER 96. DATE

97. SIGNATURE OF PHYSICIAN OR SUPPLIER 98. DATE

99. SIGNATURE OF PHYSICIAN OR SUPPLIER 100. DATE

Sample CMS HCFA Billing

UB04

1. PATIENT NAME 2. PATIENT ADDRESS 3. PATIENT CITY 4. PATIENT STATE 5. PATIENT ZIP CODE

6. PATIENT DATE OF BIRTH 7. PATIENT SEX 8. PATIENT RELATIONSHIP TO INSURED 9. INSURED'S ADDRESS (No. Street) 10. CITY 11. STATE 12. ZIP CODE

13. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 14. OTHER INSURED'S POLICY OR GROUP NUMBER 15. OTHER INSURED'S DATE OF BIRTH 16. OTHER INSURED'S SEX 17. EMPLOYER'S NAME OR SCHOOL NAME 18. INSURANCE PLAN NAME OR PROGRAM NAME

19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 20. DATE 21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 22. DATE

23. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 24. DATE OF REFERRAL 25. NAME OF PHYSICIAN OR OTHER SOURCE 26. DATE OF REFERRAL

27. DATE OF SERVICE 28. PLACE OF SERVICE 29. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) 30. CHARGES 31. TOTAL CHARGE 32. AMOUNT PAID 33. BALANCE DUE

34. SIGNATURE OF PHYSICIAN OR SUPPLIER 35. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 36. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE #

37. SIGNATURE OF PHYSICIAN OR SUPPLIER 38. DATE

39. SIGNATURE OF PHYSICIAN OR SUPPLIER 40. DATE

41. SIGNATURE OF PHYSICIAN OR SUPPLIER 42. DATE

43. SIGNATURE OF PHYSICIAN OR SUPPLIER 44. DATE

45. SIGNATURE OF PHYSICIAN OR SUPPLIER 46. DATE

47. SIGNATURE OF PHYSICIAN OR SUPPLIER 48. DATE

49. SIGNATURE OF PHYSICIAN OR SUPPLIER 50. DATE

51. SIGNATURE OF PHYSICIAN OR SUPPLIER 52. DATE

53. SIGNATURE OF PHYSICIAN OR SUPPLIER 54. DATE

55. SIGNATURE OF PHYSICIAN OR SUPPLIER 56. DATE

57. SIGNATURE OF PHYSICIAN OR SUPPLIER 58. DATE

59. SIGNATURE OF PHYSICIAN OR SUPPLIER 60. DATE

61. SIGNATURE OF PHYSICIAN OR SUPPLIER 62. DATE

63. SIGNATURE OF PHYSICIAN OR SUPPLIER 64. DATE

65. SIGNATURE OF PHYSICIAN OR SUPPLIER 66. DATE

67. SIGNATURE OF PHYSICIAN OR SUPPLIER 68. DATE

69. SIGNATURE OF PHYSICIAN OR SUPPLIER 70. DATE

71. SIGNATURE OF PHYSICIAN OR SUPPLIER 72. DATE

73. SIGNATURE OF PHYSICIAN OR SUPPLIER 74. DATE

75. SIGNATURE OF PHYSICIAN OR SUPPLIER 76. DATE

77. SIGNATURE OF PHYSICIAN OR SUPPLIER 78. DATE

79. SIGNATURE OF PHYSICIAN OR SUPPLIER 80. DATE

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95. SIGNATURE OF PHYSICIAN OR SUPPLIER 96. DATE

97. SIGNATURE OF PHYSICIAN OR SUPPLIER 98. DATE

99. SIGNATURE OF PHYSICIAN OR SUPPLIER 100. DATE

Sample UB04 Billing