

USA VOLLEYBALL MEDICAL CLAIM FORM

This form to be completed whenever a medical claim results from an injury incurred at a USA Volleyball sanctioned event.
PLEASE ANSWER ALL QUESTIONS. INDICATE "N/A" IF INFORMATION IS NOT APPLICABLE.

TO BE COMPLETED BY INJURED PARTY			
NAME (Last Name) (First Name) (Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M F
ADDRESS (Street) (City) (State) (Zip Code)	TELEPHONE NUMBER ()	OCCUPATION	
USA VOLLEYBALL PARTICIPANT #:	DATE & TIME OF ACCIDENT: ____:____ AM ____ PM ____/____/____		
REGIONAL ASSOCIATION NAME:	COACHES NAME:	PHONE #: ()	
NATURE OF INJURY		WERE YOU SEEN BY MEDICAL PERSONNEL YES WHEN _____ NO	
FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:			
A. DESCRIBE ACTIVITY ENGAGED IN AT THE TIME OF THE ACCIDENT: _____			
B. PLACE OF ACCIDENT (BE SPECIFIC): _____			
C. DESCRIBE HOW THE ACCIDENT HAPPENED: _____			
D. DID THE ACCIDENT OCCUR (CIRCLE APPROPRIATE DESCRIPTION): COMPETITION TRAVELING DIRECTLY TRAVELING DIRECTION TO/FROM OTHER (DESCRIBE): _____			
E. WITNESS: _____ PHONE: _____ WITNESS: _____ PHONE: _____			
F. WERE YOU TRANSPORTED TO A HOSPITAL YES WHICH HOSPITAL: _____ NO HOW/WHEN: _____			
ARE YOU OR YOUR DEPENDENT COVERED UNDER ANOTHER GROUP INSURANCE PLAN, GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OF THIS CLAIM? YES NO IF YES, GIVE NAME OF INSURANCE COMPANY/FIRST BENEFIT INSURER, ORGANIZATION, OR HMO PROVIDING BENEFITS BELOW:			
NAME AND ADDRESS		POLICY NUMBER	
REMARKS			
AUTHORIZATION TO RELEASE INFORMATION			
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release my information regarding medical, dental, mental, alcohol or drug abuse history treatment or benefits payable, including disability or employment related information to any Crum & Forster Insurance Company, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.			
NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF CLAIM IS ON A MINOR)	DATE	
PAYMENT AUTHORIZATION - I authorize payment directly to those physicians or providers described below and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me.		IF YES, SIGNATURE	DATE
I certify that the foregoing information is true and correct.		SIGNATURE	DATE

The issuance of this blank is not an admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the Company's legal rights in the premises.

PHYSICIAN/PROVIDER SHOULD COMPLETE OTHER SIDE

