



Notice to USA Rugby: This form should be presented in conjunction with your primary insurance card to the medical provider prior to any medical treatment.

****MEDICAL PROVIDER****

APPROVAL and BILL SUBMISSION PROCEDURE:

NOTICE TO PROVIDER:

If claimant does not have Primary Health Insurance then prior approval is required for surgeries, MRI's, CT scans, durable medical equipment and physical therapy. Please complete and fax the Medical Approval Form.

This USA Rugby policy is a secondary policy and Clean Claim Forms (UB04 or HCFA-1500) and Medical Reports should be submitted to Injured Participants **PRIMARY HEALTH INSURANCE** prior to submission to Consolidated Health Plans (CHP). Once payment or denial is made by primary health insurance, Clean Claim Forms (UB04 or HCFA-1500), Medical Reports, and the Primary Explanation of Benefits should be submitted to the address below. If injured participant does not have Primary Health Insurance then Clean Claim Forms (UB04 or HCFA-1500) and Medical Reports can be submitted initially to:



**Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
Fax: (413) 733-4612**



Instructions for Reporting an Injury

1. Injured participant or parents of injured participant (if a minor) will complete the USA RUGBY INCIDENT REPORT.
2. Once INCIDENT REPORT is complete email report to: usarugbyclaims@usi.com. INCIDENT REPORT should be sent to USA Rugby as soon as possible after the injury but must be within 30 days of the injury to ensure coverage.

***** No bills can be processed by Consolidated Health Plans (CHP) until a completed incident report has been sent to USA Rugby*****

3. This USA Rugby policy is a secondary/excess accident medical policy and is designed as a supplement to your family health insurance coverage. You must file a claim with your family health insurance prior to filing anything under this policy. Please be sure to supply your medical provider your family health insurance information as primary coverage and the USA Rugby Insurance program information as secondary. If you provide the above information to the medical providers, they will automatically bill the primary and secondary (USA Rugby) insurance with the proper itemized billing statements and the required primary insurance Explanation of Benefits (EOB's). If you do not have family health insurance, the USA Rugby Insurance program would be filed and the medical providers should be provided with the Medical Approval Form.
 4. Important ** If you do not have family health insurance and your medical treatment is not an emergency, please note that the following treatments require approval prior to service: Surgeries, MRI's, CT Scans and Physical Therapy. If you are having any of the above treatment you will need to make sure that your health care provider receives the attached Medical Approval Form prior to services.
 5. Treatment must commence within 30 days from the date of the injury to be eligible for Accident Medical Expense Benefits. Treatment must commence within 7 days of onset of an Emergency Sickness to be eligible for the Emergency Sickness Medical Expense Benefit. This policy has a 52-week benefit period from the date of injury. This means only charges incurred within 52 weeks from the date of injury will be covered under this policy. Any charges incurred after the 52-week benefit period will not be covered.
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1. PLEASE FULLY COMPLETE THIS FORM
 2. EMAIL THIS FORM TO USA RUGBY TO:
usarugbyclaims@usl.com



USA RUGBY INCIDENT REPORT

IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE PROVIDED AND LEGIBLE. OMISSION OF INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.

INJURED PERSON INFORMATION:

(PRINT/TYPE REQUIRED)

Last Name _____ First Name _____ MI _____

Date of Birth _____ Current Age _____ Male Female

Address _____ Email _____

City _____ State _____ Zip _____ Phone _____

Employer _____ Spouse's Name _____

(If Minor)

Father's Name _____ Mother's Name _____

Are you a (choose one): ATHLETE COACH OFFICIAL OTHER

FAMILY/Primary HEALTH INSURANCE

(Primary Health Insurance MUST be filed prior to this policy)

Insurance Company: _____

Policy holder's name: _____

Policy Number: _____

Group Number: _____

TIME, PLACE AND DETAILS OF INCIDENT:

Date of Incident _____ Time of Incident _____ AM PM

Body Part Injured: _____ Right Left

Type of Injury (choose one): Laceration Sprain/Strain Fracture Contusion Concussion Dental

Other: _____

Severity (choose one): Report only Minor Serious Critical Fatality

Did you receive onsite care? Y N Were you taken by ambulance to a hospital? Y N

Type of Event: Match Tournament Practice Championships

Name of event or teams competing against:

Describe what happened: _____

Was there a certified coach at this event? Y N If so include name _____

Was there a certified trainer at the event? Y N If so, include name: _____

Was there any other witness to the incident? Y N

WITNESSES:

(If there was a witness please complete this section)

Witness name: _____ Witness name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE **CONSOLIDATED HEALTH PLANS**, OR THEIR REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH **CONSOLIDATED HEALTH PLANS**, OR THEIR REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

BY MY SIGNATURE BELOW I CERTIFY THAT THIS INJURY OCCURRED TO A USA RUGBY REGISTERED MEMBER DURING A USA RUGBY SANCTIONED EVENT AND THAT I HAVE LISTED ANY EXISTING HEALTH INSURANCE COVERAGE ABOVE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHERMORE UNDERSTAND THAT OMISSION OF REQUESTED INFORMATION OR FRAUDULENT STATEMENTS CAN BE A CRIME.

I authorize the claims administrator, Consolidated Health Plans, to email information about my USA Rugby Insurance Plan.

Claimant Signature _____ Date _____

Please have this section signed by a USA Rugby Certified Coach or Official:

Club Name of injured: _____ Territory where incident occurred: _____

Was Athlete treated by Trainer and/or Official at School: ____ Yes ____ No

If Yes, please indicate the date(s) of treatment: _____

I ASSERT THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INCIDENT OCCURRED ON THIS DATE _____

WHILE (athlete, coach or Official name) _____ WAS PARTICIPATING IN A SANCTIONED USA RUGBY EVENT.

COACH or OFFICIAL NAME (print) _____ Title _____

COACH or OFFICIAL SIGNATURE _____ Date _____

(For USA Rugby use ONLY)

USA RUGBY REPRESENTATIVE NAME: Jess Dombrowski Title: Membership Services Coordinator (USA Rugby)

SIGNATURE _____ Date _____

By entering your name above, 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 STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

Alaska and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and 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, Maryland, West Virginia and Rhode Island: Warning: 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.

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, Indiana: 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: WARNING: 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.

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.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

- a) In any written statement;
- b) In the filing of a claim; or
- c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;

3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

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.

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 subjects the person to criminal and 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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico and 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.

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.

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: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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.