Important Notice Regarding Fraud

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and 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.
- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ***For residents of California***: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***For residents of 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.
- ***For residents of the 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.
- ***For residents of 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.
- ***For residents of 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.
- ***For residents of Maine, Tennessee 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.
- ***For residents of 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.
- ***For residents of 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.
- ***For residents of 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.
- ***For residents of 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.
- ***For residents of 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.

Important Notice Regarding Fraud

- ***For residents of 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.
- ***For residents of 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.
- ***For residents of Oregon:*** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of 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.
- ***For residents of 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.
- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.

How to file a Medical Claim

(For Special Risk and Participant Accident Insurance Policies)
Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:
Provident Agency, Inc.
Attn: Claims Department
P.O. Box 11588 Pittsburgh, PA 15238
Fax: 412-963-0148
claims@providentins.com

Step 1: The Participating Organization (NOT the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Statement.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

Step 2: The Parent/Guardian or Adult Claimant Should:

- Fully answer each item in Part II, including the claimant's personal information, parent's information, along with other insurance information.
- In order to ensure we receive complete claim information, we require providers to submit standardized itemized bills (called "**UB04"** for hospital charges and/or a "**CMS-1500**" for physician charges).
- Providers may bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). **We are Primary over State provided Insurance (i.e. all Medicaid programs) and Non-active Duty TRICARE.**
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment, or zero balance information) claim payment is sent directly to the medical providers.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Helpful information for submitting claims

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will be sent back to injured party, to complete missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Step 3: Submit the Completed Notice of Claim (Claim Form) via either by mail, fax, or email listed above.

Provident Agency, Inc.
Attn: Claims Department
P.O. Box 11588 Pittsburgh, PA 15238
Fax: 412-963-0148
claims@providentins.com

1. Please Fully Complete This Form
2. See Filing Instructions Attached
3. Mail To

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity, or Sport:

Claimant's Name (Injured Person)	The Injured Person Was A:	Date and Time Of Accident:
	☐ Participant ☐ Staff Member ☐ Other	

Place Where Accident Occurred:	Type of Injury: (Indicate Part Of Body Injured - e.g. broken arm, etc.)

Describe How Accident Occurred - Provide All Possible Details:

Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident:
		☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Did Accident (Check Yes or No for Each of The Following):

A.	During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?	☐ YES	☐ No
B.	On Activity Premises:	☐ YES	☐ No
C.	While Traveling Directly and Uninterruptedly to Or from the Activity?	☐ YES	☐ No
D.	During A Participating Organization Practice or Competition?	☐ YES	☐ No
E.	Did Injury Result in Death:	☐ YES	☐ No

Signature of Participating Organization Representative:	Name & Title of Participating Organization Representative:	Date:

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Best Contact Number (Included Area Code):	Social Security Number (Of Injured):	Gender (Of Injured):	Date of Birth (Of Injured):
		☐ M ☐ F	

Address (in which information should be mailed to):

Do you/spouse/parent have medical/health care, or are you 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 an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning 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 or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____