ADMINISTRATIVE CONCEPTS, INC.

PO Box 4000 • Collegeville, Pennsylvania 19426 • Telephone: (610) 293-9229 • Fax: (610)293-9299 • www.visit-aci.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE PROCESSING OF A CLAIM FILED UNDER THE INSURANCE POLICY

I hereby authorize Administrative Concepts, Inc. to obtain **Protected Health Information** and to disclose such PHI to the individual(s) or entity(ies) indicated below, for the *express* and *limited* purpose of assisting in the processing of my claim.

Information to be Used or Disclosed May Include:

- ☐ Provider name, address & specialty (required)
- ☐ Dates of service (required)
- ☐ Cost of services (required)
- ☐ Medical diagnosis (optional)
- ☐ Services rendered (optional)
- ☐ Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

- ☐ Student Health Service Staff
- ☐ Employer
- ☐ A Specific Individual, as follows: _____
- ☐ Student Affairs Staff
- ☐ Association Representative

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and,

that if the person or entity that receives this information is not a business associate, health plan, health care clearinghouse, or health care provider as defined in the *HIPAA Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,

that I may revoke the authorization at any time by notifying Administrative Concepts, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by Administrative Concepts, Inc. *prior* to my revocation; and,

that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires 365 days after signing or upon my request to Administrative Concepts, Inc. to terminate the authorization, whichever is earlier.

Insured Member's Name: (print) _____

Member ID Number _____ **Date of Birth:** _____

Claimant is: ☐ **Self** ☐ **Dependent (print full name and indicate relationship to insured)**

_____

Patient's or Authorized Representative's Signature: _____

Date: _____ **If Authorized Representative, Relationship to Patient:** _____

Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: (888) 293-9229
Email: aciclaims@acitpa.com

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI ☐ FEMALE ☐ MALE
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
INSURED'S DATE OF BIRTH (MM/DD/YY)	INSURED'S PHONE NUMBER	INSURED'S MEMBER ID NUMBER	VISA TYPE: ☐F1 ☐J1 ☐ OTHER _____
VISA NUMBER	PASSPORT NUMBER	PASSPORT ISSUING COUNTRY	

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME		CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
CLAIMANT'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? Sickness Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:

   _____

   _____

   _____

   Date of Injury: _____

   b) Did injury occur at work? ☐ No ☐ Yes If yes, name of employer: _____

   c) Did injury occur during a motor vehicle accident? ☐ No ☐ Yes

   d) Did injury occur during practice or play of school-sponsored sports? ☐ No ☐ Yes If yes, please complete information about the sport below.

   Name of Sport: _____ ☐Intercollegiate ☐ Intramural/Club

   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ No ☐ Yes ☐ N/A (skip to Section 3)

   If yes, signature and title of health center official: _____

3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ No ☐ Yes ☐ N/A

   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION (CURRENT)

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes

   If yes, who is the Policyholder? ☐Self ☐ Parent ☐Spouse Name of Insurance Carrier: _____

   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

   Primary Insured's Name (Parent/Spouse/Self): _____

SECTION 4 –PRIOR INSURANCE COVERAGE

5. Did you have *prior* insurance which covered your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes

   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____

   Coverage Effective Date: _____ Coverage Term Date: _____

   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____

   Primary Insured's Name (Parent/Spouse/Self): _____

Clear Form

SECTION 5 – ASSIGNMENT OF BENEFITS

6. Indicate below to whom payment is to be made:

☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.

☐ Expenses have been paid by the patient/insured. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Services, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature_____ Date _____

If student is under age 18, must be signed by a parent, guardian, or sponsor.

YOU CAN SUBMIT THIS COMPLETED FORM, ALONG WITH YOUR CURRENT CLASS SCHEDULE, BY MAIL OR FAX USING THE INFORMATION BELOW. ALTERNATIVELY, YOU MAY LOG INTO THE MEMBER PORTAL AT SECURE.VISIT-ACI.COM TO NOTIFY US OF A CLAIM.

Claims Mail:	Administrative Concepts, Inc. P.O. Box 4000, Collegeville, PA 19426-9000
Fax:	(610) 293-9299
Customer Service:	(888) 293-9229
Email	aciclaims@acitpa.com

ITEMIZED BILL REQUIREMENTS

Hospital and Medical Bills

A fully itemized billing statement is required for claims payment consideration. The itemized billing statement must include the following:

- Patient's name
- Patient's date of birth
- Provider's name
- Provider's address
- Provider's tax identification number
- Diagnosis code(s)
- Date of service
- Procedure code(s)
- Amount charged for each procedure

Note: If your billing statement does not include this information, please contact the provider and ask them to send a copy to you to include with this form. (The fully itemized billing form is also known as a HCFA 1500, CMS 1500, UB04, and CMS 1450.)

Prescription Drug Receipts

A fully itemized prescription drug receipt is required for claims payment consideration. The prescription drug receipt must include:

- Pharmacy name
- Rx number
- Patient's name
- Name of the medication(s)
- Prescribing physician's name
- Dosage or quantity dispensed
- NDC code number
- Date of service
- Amount charged

Note: Please do not send a cash register receipt listing only the charges. You must send the full receipt or print-out that includes all of the above.

If you (or the medical provider) do not provide the Rx receipt as indicated above, your claim may be denied until the information is provided.

CLAIM FORM FRAUD STATEMENT - 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.

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.

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.

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 fins 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.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

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.

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.

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: 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.

TENNESSEE: 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.

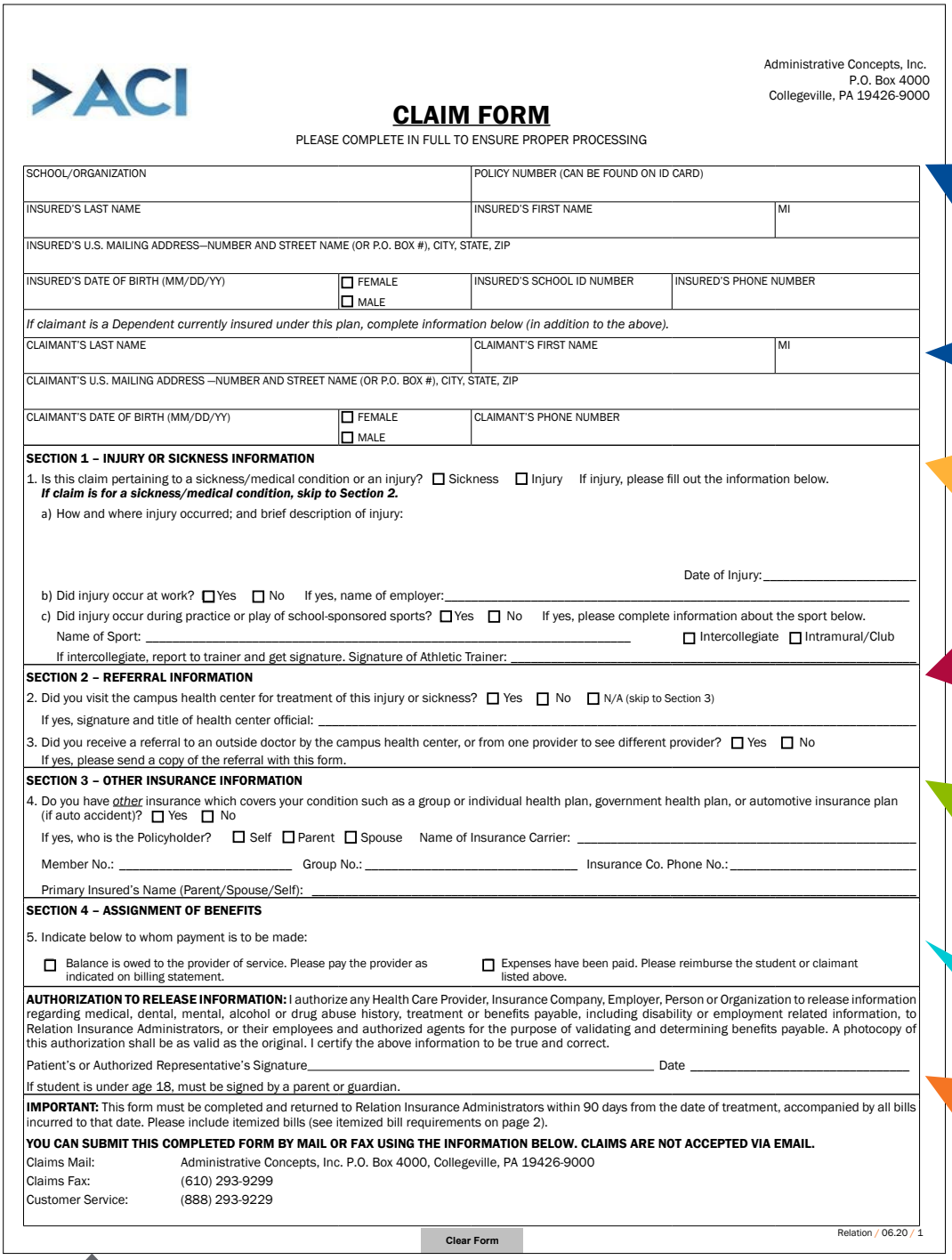
CLAIM FORM FRAUD STATEMENT - continued

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 claim containing a false or deceptive statement may have violated state law.

HOW TO COMPLETE A CLAIM FORM

ALL INFORMATION SHOULD BE COMPLETED BY THE STUDENT



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Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
INSURED'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME		CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS –NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
CLAIMANT'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? ☐ Sickness ☐ Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:

   Date of Injury:_____
   b) Did injury occur at work? ☐ Yes ☐ No If yes, name of employer:_____
   c) Did injury occur during practice or play of school-sponsored sports? ☐ Yes ☐ No If yes, please complete information about the sport below.
   Name of Sport: _____ ☐ Intercollegiate ☐ Intramural/Club
   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ Yes ☐ No ☐ N/A (skip to Section 3)
   If yes, signature and title of health center official: _____
3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ Yes ☐ No
   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ Yes ☐ No
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____
   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____
   Primary Insured's Name (Parent/Spouse/Self): _____

SECTION 4 – ASSIGNMENT OF BENEFITS

5. Indicate below to whom payment is to be made:

   ☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.

   ☐ Expenses have been paid. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Administrators, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature_____ Date _____

If student is under age 18, must be signed by a parent or guardian.

IMPORTANT: This form must be completed and returned to Relation Insurance Administrators within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements on page 2).

YOU CAN SUBMIT THIS COMPLETED FORM BY MAIL OR FAX USING THE INFORMATION BELOW. CLAIMS ARE NOT ACCEPTED VIA EMAIL.

Claims Mail: Administrative Concepts, Inc. P.O. Box 4000, Collegeville, PA 19426-9000
Claims Fax: (610) 293-9299
Customer Service: (888) 293-9229

Clear Form

Relation / 06.20 / 1

1. Enter Student Information
This section asks for basic identifying information, such as name, address, and student ID. International students should use their current U.S. address, not their permanent home address abroad.

1b. If an insured dependent is filing the claim, fill out the "claimant" section with dependent's information.

2. Injury or Sickness Information
This section asks for all the details of the sickness or injury. If reporting an injury, it's important for the claim administrator to understand if injury happened while on the job, playing sports, or riding in an automobile.

3. Referral Information
If a health center referral is required, or if the deductible is waived with a health center referral, this section must be completed and the referral must be attached.

4. Other Insurance Coverage
If the student has coverage under another plan, the school plan will pay secondary, in which case the student must submit a claim to the other insurance first, then to Relation second for covered amounts not paid by the other plan.

5. Assignment of Benefits
This section instructs the claims administrator to whom payments should be made.

6. Sign and Date
This section is used as a release of personal information so that medical providers and the claims administrator can share pertinent medical information.

7. IMPORTANT
This form must be completed and returned to the company within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills.

8. ATTACH STUDENT HEALTH CENTER REFERRAL
If a health center referral is required, or if the deductible is waived with a health center referral, make sure to include health center referral.

9. ATTACH ITEMIZED BILLS
Make sure to send all itemized bills, as well as prescription drug receipts, if applicable, with claim form. It's a good idea to write your name and student number on all bills you attach.

10. SEND THE COMPLETED FORM EITHER BY MAIL OR FAX.

Confidential Communication Request

Complete this form to designate an alternate address and/or phone number for receiving confidential medical information from the claims administrator. Please complete a form for each person requesting an alternate address.

For questions about this form, please contact Administrative Concepts, Inc. at (800) 476-4802.

1. ENTER INSURED MEMBERS INFORMATION:

MEMBERS LAST NAME	MEMBERS FIRST NAME	MI

PROGRAM NAME	POLICY NUMBER	MEMBER ID #

2. ENTER REQUESTOR'S CURRENT INFORMATION:

LAST NAME (if different from above).	FIRST NAME (if different from above)	MI

MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #)	APT/UNIT #

CITY	STATE	ZIP

PHONE NUMBER	DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE

EMAIL ADDRESS

3. ENTER NEW DESIGNATED ALTERNATE CONTACT INFORMATION:

MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #)	APT/UNIT #

CITY	STATE	ZIP

PHONE NUMBER	EMAIL ADDRESS

4. CHANGE TO ALTERNATE CONTACT INFORMATION FOR THE FOLLOWING DEPENDENTS:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YY)	GENDER
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE
CHILD				☐ FEMALE ☐ MALE

Note: Alternate contact for dependent children under age 18 can only be authorized by a parent or legal guardian.

5. REQUESTOR SIGNATURE:

SIGNATURE _____ **DATE**_____

6. RETURN THIS FORM TO: Administrative Concepts, Inc., PO Box 4000, Collegeville, Pennsylvania 19426

Fax # 888-293-9299 Email: ACICLAIMS@ACITPA.COM

Please allow up to 10 business days for this change to go into effect.

ADMINISTRATIVE CONCEPTS, INC.