

Here is the information that needs to be completed in order for a claim to be reported for the WSYSA. Make sure that all of the steps are followed or **THE CLAIM CANNOT BE REPORTED!!!**

PLEASE READ THE FOLLOWING INFORMATION THOROUGHLY BEFORE FILLING OUT THE FORMS.

- ◆ Please note that there are **TWO (2)** pages to the claim form and they **BOTH** must be completed.
- ◆ Make sure that these forms are filled out **COMPLETELY AND HAVE ALL THE CORRECT INFORMATION** or they will be sent back to us and then to you, therefore, they will not be filed in a timely manner.
- ◆ Also, please make sure that an Organization Official and/or Coach has signed and left a number where he/she can be reached in the appropriate section.

Please send the **CLAIM FORMS** to the following address:

Washington State Youth Soccer Association
500 S. 336th St. Suite 100
Federal Way, WA. 98003

BEFORE you send any bill information to WSYSA **PLEASE READ THE FOLLOWING INFORMATION THOROUGHLY:**

ALL BILLS MUST HAVE THE FOLLOWING INFORMATION BEFORE THEY CAN BE PROCESSED:

- ◆ An **Explanation of Benefits (EOB)** from your primary insurance carrier. This is an explanation of what they have paid and what is still outstanding. **THIS FORM IS NECESSARY IN ORDER FOR A CLAIM TO BE PAID.** If you send this in initially, it will not delay the process. If you do not have insurance please enclose a letter from your employer stating that no insurance coverage is available/opted for.
- ◆ **ALL** bills must be on one of two different **standardized forms**. For **ALL** services rendered **PLEASE** make sure that you send in the standardized form. There are two different forms; the HCFA 1500 or the UB 92. If you request your provider to bill you on one of these forms for insurance purposes, the provider will know which one to use.
- ◆ **ITEMIZED STATEMENTS WILL NOT BE PAID! ALL BILLS MUST BE ON STANDARDIZED HCFA 1500 FORM, OR UB 92 FORMS.**

If you have any further questions while filling out the above papers or at any other time, please contact Mary Warren at mary@wsysa.com or (253) 476-2237 Ext 107

YOUTH SOCCER ACCIDENT PROOF OF LOSS

SEE REVERSE FOR INSTRUCTIONS



TO BE COMPLETED BY CLAIMANT

NAME OF CLAIMANT (Last Name) (First Name) (Middle Initial)			SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS OF CLAIMANT (Street) (City) (State) (Zip code)			TELEPHONE NUMBER ()	OCCUPATION	
DATE & TIME OF ACCIDENT				ACCIDENT DUE TO EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NATURE OF INJURY					
FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING:					
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT					
B. PLACE OF ACCIDENT (BE SPECIFIC)					
C. DESCRIBE HOW ACCIDENT HAPPENED					

MEDICAL AUTHORIZATION

I hereby authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disability.	Please Sign Here: _____ Claimant (if Adult) or Parent /Guardian	_____ Date
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PAYMENT AUTHORIZATION

I hereby authorize payment of benefits directly to the providers rendering services.	Please sign here: _____ Claimant (if Adult) or Parent/Guardian	_____ Date
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STATEMENT OF OTHER INSURANCE

1. Name and Address of Claimant's Employer: (If a minor, complete # 2 & 3)			
2. Father's Name or Guardian:	Occupation:	Name and Address of His Employer:	Phone #:
3. Mother's Name or Guardian:	Occupation:	Name and Address of Her Employer:	Phone #:
4. Do you have a Group, Personal Healthcare or Medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of your Health Care Provider		Address	

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Signature _____

Date _____

Claimant (if Adult) or Parent/Guardian

Signature _____

Date _____

Coaches Signature

TO BE COMPLETED BY WASHINGTON STATE YOUTH SOCCER ASSOCIATION

EFFECTIVE DATE OF COVERAGE September 1, 2004	COVERAGE TERMINATION DATE, IF APPLICABLE September 1, 2005	POLICY NUMBER 4102AH244636-0	NAME OF GROUP POLICYHOLDER Washington State Youth Soccer Association
ADDRESS OF POLICYHOLDER (Street) 500 S. 336 th St. Suite 100	(City) Federal Way	(State) WA	TELEPHONE NUMBER (253) 476-2237
		98003	(Zip Code)
IF ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SUPERVISED BY YOUR ORGANIZATION, DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.			
REMARKS:			
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.		President, Washington State Youth Soccer Association	DATE

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM:

1. **IMMEDIATELY** submit a claim for all medical expenses to the Company that administers your own personal or group insurance or healthcare plan (including Major Medical coverage). If you have coverage through an HMO or similar facility, you **must** use that facility first or the claim will not be covered under this policy.
2. After your other insurance or healthcare plan has paid the medical expenses up to the policy limits, attach any unpaid bills and copies of payments made by your insurance company (Explanation of Benefits) to this claim form and mail to the address shown below.
3. Please check and make sure that:
 - a) An Official or Administrator of the Policyholder has completed his/her section of the claim form.
 - b) You have completed and signed the Parent/Guardian or Insured's Statement of other Insurance.
 - c) The Medical Records Authorization **MUST** be signed and dated. If you want payments to be sent directly to your doctor or healthcare provider, sign the Payment Authorization Section.
 - d) You have attached all unpaid bills to this form.
 - e) You have attached any Explanation of Benefits forms that you have received from your Primary insurance carrier or other healthcare plan.
 - f) You have completed the front of this form.
4. Subsequent bills should be sent in as you receive them. Please write the claimant's name, policy number and date of accident on all subsequent bills. **A new claim form is not necessary.**

If you need further information, please contact Mary Warren at mary@wsysa.com or (253) 476-2237 Ext 107

MAIL THIS FORM AND ALL ITEMIZED BILLS TO:

Washington State Youth Soccer Association
500 S. 336th St. Suite #100
Federal Way, WA 98003

PLAN ADMINISTRATOR:
Bollinger, Inc
P.O. BOX 390, SHORT HILLS, NJ 07078-0857
TELEPHONE (800) 526-1379 Sports Claims Division