Co-ordinated Benefit Plans, on behalf of AXIS Insurance Company
P.O. Box 20874, Tampa, FL 33622
Phone: 866-669-7577 Fax: 800-561-8084
Email:AXISClaims@CBPINSURE.COM

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number: COSBAG1-STU0001	**Policyholder/Organization/School District Name:**		**Event, Activity or Sport:**	
Name of School/Team/Club/Other:	**Street Address**	**City**	**State**	**Zip Code**
Claimant's Name (Injured Person)	**Social Security Number**	**Gender** ☐ M ☐ F	**Date of Birth**	**E-Mail Address**

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	**Place where Accident Occurred**	**The injured person was a:** ☐ Participant ☐ Staff Member ☐ Other
Dental Claims	**Indicate which Teeth were Involved in the Accident**	**Describe Condition of Injured Teeth Prior to Accident:** ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)		**Did Injury Result in Death?** ☐ YES ☐ NO

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (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? ☐ YES ☐ NO or competition? ☐ YES ☐ NO

Signature of Participating Organization Representative	**Name and Title of Representative**	**Date**

PART II – OTHER INSURANCE STATEMENT

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 ? YES ☐ NO ☐

If Yes, name of insurance company: _____ **Policy #:** _____

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

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

Are you eligible to receive benefits under any governmental plan or program, including Medicaid?

☐ YES ☐ NO If yes, please explain: _____

IF OTHER INSURANCE EXISTS, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS

PART III – AUTHORIZATIONS

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

SIGNATURE _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, 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 ***Co-Ordinated Benefit Plans, on behalf of AXIS Insurance Company*** or its designated administrator**.** This authorization shall remain valid for a period of two years from the date signed. A photo static copy of this authorization shall be considered as effective and valid as the original. A copy of the authorization is available upon request of the company.

I agree that should it be determined, at a later date, there is other insurance (or similar), to reimburse ***Co-Ordinated Benefit Plans, on behalf of 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 subject to prosecution for insurance fraud.

SIGNATURE _____ **DATE** _____

How to File a Medical Claim

(For Student, Athletic, and Special Risk Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

Co-ordinated Benefit Plans, on behalf of AXIS Insurance Company
P.O. Box 20874, Tampa, FL 33622
Phone: 866-669-7577 Fax: 800-561-8084
Email:AXISClaims@CBPINSURE.COM

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail or by email.**

The Participating Organization (not the Parent, Claimant or Agent) should:

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

The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on and sign where indicated on the bottom of the Claim Form.

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an Insurance company is not an admission of coverage
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges – examples below).
- 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 generally sent directly to the medical providers.