Pathfinders Insurance

ACE Accident and Sickness Medical Claim Form

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
PHONE: 1 (888) 951-4ARM (4276) | FAX: (301) 453-7060
EMAIL: claims@adventistrisk.org

How to File a Claim

1. Complete sections A, B, D, and E on the attached claim form.
    - Please complete a new claim form for each new incident (i.e. cold, broken arm, etc.).
2. Attach the following documents:
    - All medical bills and receipts relating to the incident.
3. Send the completed and signed (there are two places to sign) claim form and all required documents to:

Adventist Risk Management, Inc.
Claims and Legal Services
12501 Old Columbia Pike
Silver Spring, MD 20904
Email: claims@adventistrisk.org
Phone: 1 (888) 951-4ARM (4276)
Fax: (301) 453-7060

4. Retain a copy for your records.

This is not comprehensive health insurance. Please familiarise yourself with the summary of benefits provided by the Adventist Volunteer Services Office. There are provisions, limitations, and exclusions in the policy. ACE Insurance Company makes the final determination on payment or denial of all claims.

A CLAIM ADJUSTER WILL CONTACT YOU IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

Accident & Sickness Medical Claim Form

Please mail completed Claim Form with itemized bills and receipts to:
(To expedite your claim, please fax it with readable receipts.)

Claims & Legal Services
Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904

Phone: (301) 453-7400 | 1-888-951-4ARM (4276)
Fax: (301) 453-7060
E-mail: claims@adventistrisk.org

Please complete Sections A, B and C. Complete Section D if the claim is for a dependent, other coverage is in effect, or if the claim is accident related. Complete a separate Claim Form for each individual. Attach bills and/ or receipts and return to the address listed above. Please note that you may scan and email or fax claims.

SECTION A INSURED / PATIENT INFORMATION			
Name of Group		Policy Number	
Insured's Name		Insured's Date of Birth	
Patient's Name		Patient's Date of Birth	
Home Address			
Please provide telephone and facsimile numbers, with country and city codes.			
Home Phone Number	Work Phone Number	Fax Number	E-mail Address
Manager's Name	Work Phone Number	Fax Number	E-mail Address

SECTION B TRAVEL INFORMATION Please complete this section	
My Business location is in (country of employment)	
I / we left the above country on (Day / Month / Year)	
I / we visited the following countries	
I / we are expected to return home on (Day / Month / Year)	
The purpose of my / our trip was	

SECTION C PAYMENT INFORMATION Please complete Option #1, #2 or #3	
☐ OPTION #1 - Payment to INSURED Please indicate where you wish the payment to be sent and in what currency. ☐ Your home address as listed above ☐ Direct deposit to your bank account	
Name on account:	Account #:
Bank Name:	Swift Code:
Bank Address:	Currency:
IBAN:	
☐ OPTION #2 - Payment to a Provider, e.g. hospital, doctor Please complete Provider's name and address in Section E of this Claim Form	
☐ OPTION #3 - Payment to the Employer	
Employer's Name:	

Employer's Address:

Payment Authorisation: I authorise payment directly to me, my employer or to the healthcare provider in Section E of this Claim Form.

INSURED'S SIGNATURE _____ DATE _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorise the release of all records or other information which may be necessary to determine claim payment.

PATIENT'S SIGNATURE _____ DATE _____

SECTION D OTHER COVERAGE INFORMATION Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.	
Do you have any other insurance? ☐ Yes ☐ No If yes, please provide source of insurance.	
Is this claim accident related? ☐ Yes ☐ No Is this claim worked related? ☐ Yes ☐ No If yes, please provide documents relating to accident or work injury.	
If claim is due to an accident, are you seeking reimbursement from another source? ☐ Yes ☐ No If yes, please provide source of insurance.	
Spouse's name	Spouse's insurance company
Spouse's employer and telephone #	
Dependent's date of birth	Is your dependent a full-time student? ☐ Yes ☐ No If yes, please provide documentation of current academic registration.

SECTION E DOCTOR OR PROVIDER Please complete this section.			
Name of doctor or provider of service			
Address			
Telephone #			
Diagnosis or nature of illness or injury			
Date of illness (first symptom) or injury	Date first consulted for this condition		
Hospital confinement dates: From To	Date able to return to work		
Total disability dates: From To	Partial disability dates: From To		
Patient's account #	Amount paid	Balance due	
Place of service	Diagnosis code and description		

Date of Service	Procedure code and description/ Pre-determination of benefits	Charges	Total charges

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

- I agree that a photographic copy of this Authorization shall be a valid as the original.
- I understand that I or my authorized representative may request a copy of this authorization.
- I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	Relationship, If Other Than Insured	Dated

Address:

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident &Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents 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.

Florida
Any person who knowingly and with intent in 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.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania
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 and subjects such person to criminal and civil penalties.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.