



1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
 3. MAIL TO
 Consolidated Health Plans
 2077 Roosevelt Ave
 Springfield, MA 01104



(VAMP) **PART I – POLICYHOLDER’S REPORT**

Policy Number SRPO-50571-609		Policyholder Name:		Event, Activity or Sport:	
Claimant's Name (Injured Person)		Social Security Number	Gender <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Other			
Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial			
Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)			Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Describe How Accident Occurred – Give All Possible Details

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

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? YES NO

B. On activity premises? YES NO

C. While traveling directly and uninterruptedly to or from the athletic event? YES NO

D. During intercollegiate/scholastic athletic practice? YES NO or competition? YES NO

Signature of Policyholder Representative	Name and Title of Policyholder Representative	Date
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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 source? 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 Medicare?
 YES NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

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 **Consolidated Health Plans, Inc.** 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 subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____