



# 2024/25 ISR Insurance Claim Form

If you are injured in a USAC sanctioned event, please complete this form to file a claim. Once complete return back to Nikki@USACNation.com or Fax 317-454-0225, or USAC Racing 4910 W. 16<sup>th</sup> St. Speedway, IN 46224.

**ALL CLAIMS PAST 90 DAYS WILL BE DENIED.**

Member Name \_\_\_\_\_

Annual Member# \_\_\_\_\_ Single Event Member ☐

Event Date \_\_\_\_\_ Location \_\_\_\_\_

Race Name/Class \_\_\_\_\_

Primary Insurance Name \_\_\_\_\_

☐ *I DO NOT have primary insurance*

**TO SUBMIT A CLAIM PLEASE RETURN THE FOLLOWING  
TO NIKKI@USACNATION.COM.**

- USAC Red Flag Report - **FILLED OUT BY RACE DIRECTOR**
- These attached Insurance Claim Forms
- Copies of all itemized bills **(As they are received)**
- Copies of all primary insurance Explanation of Benefits
- Copies of additional documents that support your claim

**\*DO NOT WAIT FOR BILLS TO SUBMIT THIS FORM.**

**THE CLAIMS ADJUSTER WILL CONTACT YOU IF ADDITIONAL  
INFORMATION IS NEEDED.**



Cambridge Administrators  
5832 South 142<sup>nd</sup> St, Suite A  
Omaha, NE 68137  
Toll Free: (855) 868-7554 Fax: (402) 504-6447  
Email: [info@CambridgeAdministrators.com](mailto:info@CambridgeAdministrators.com)



## Instructions for Submitting a Blanket Accident Claim

**Item 1 should be sent to USAC Racing via regular mail or email as outlined below:**

1. This claim form must be submitted for each individual accident/sickness within 90 days of the occurrence. Once completed, the **Cambridge Administrators Claim Form** along with the **USAC Racing Coversheet** and the **Race Incident report (filled out by race director)** should be sent directly to: USAC Racing 4910 W 16<sup>th</sup> St, Speedway IN 46224 or may be emailed to: [Nikki@USACNation.com](mailto:Nikki@USACNation.com) Please use a separate sheet of paper to answer any questions that require more space than what is allotted for in this form. Any separate sheet must also be signed and dated by the person providing the information

**Items 2 through 4 must be sent directly to Cambridge Administrators via regular mail or email as outlined below and above.**

2. Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan, the bill must first be submitted to the primary insurance for consideration.
3. Please ask your providers to submit all medical bills along with the corresponding Explanation of Benefits (EOB) from the primary insurance. The bills must be itemized for all services. A physician's office should submit an invoice utilizing a CMS 1500. A hospital and/or emergency room should submit an invoice utilizing a UB04 (CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital). If the provider will not submit the bill(s) directly, please request these forms from the provider(s). A balance due or patient statement is not acceptable and will only delay processing.
4. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be marked incomplete and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. Our explanation of benefits form or letter advising what is needed will be sent to the address of the claimant listed on the claim form.

## Claim Submission Checklist

Use the checklist below to assure a properly submitted medical claim is being sent:

- ☐ Is the claim form completed in full by the claimant and signed under Part D?
- ☐ Part D of the claim form will be signed by a policyholder official or staff member once submitted per Step 1 above.
- ☐ If bills are attached, are they in either a CMS 1500 or UB04 form?
- ☐ If the claimant has primary health insurance, has the claim been submitted first to the primary health insurance? If so, are copies of primary insurance EOBs (explanation of benefits) attached?
- ☐ If any payment has been made by the patient, proof of payment must be included or payment will be made to the provider (doctor or hospital).

### Send this Completed Claim Form to:

[Nikki@USACNation.com](mailto:Nikki@USACNation.com)

Or to: USAC Racing  
4910 W 16<sup>th</sup> St  
Speedway IN 46224

### Send all additional bills or information to:

Cambridge Administrators  
5832 South 142<sup>nd</sup> St, Suite A  
Omaha, NE 68137



Cambridge Administrators

5832 South 142<sup>nd</sup> St, Suite A

Omaha, NE 68137

Toll Free: (855) 868-7554 Fax: (402) 504-6447

Email: info@CambridgeAdministrators.com



### Blanket Accident Insurance

#### Accident Claim Form for Racing

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) and/or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978)

#### Section A Claimant Information

Group / Policyholder	<input type="text" value="Int'l Snowmobile Racing PAI L264020181405"/>	Last five digits of SS#	<input type="text"/>
Claimant Name	<input type="text"/>	Date of Birth	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text" value="M/F"/>
Claimant Address	<input type="text"/>		
Email Address	<input type="text"/>	Best contact phone number	<input type="text" value="( )"/>

Please note that the last five digits of the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.

#### Section B Accident Information

Accident Date (month / day / year)	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>	Type of Sport/Activity/Event	<input type="text"/>
Location	<input type="text"/>	Injury Occurred to:	<input type="checkbox"/> Driver <input type="checkbox"/> Official <input type="checkbox"/> Crew <input type="checkbox"/> Spectator <input type="checkbox"/> Other _____
Type of injury (indicate part(s) of body injured - i.e., broken right arm, sprained left ankle, etc.)			
<input type="text"/>			

Describe how accident happened - give all possible details (if additional space is needed, please attach on a separate sheet)

#### Section C Other Coverage Information

Does the claimant/injured person have other health insurance? ☐ YES ☐ NO If YES, complete below:

Policyholder Name (s):	<input type="text"/>
Policyholder ID number(s):	<input type="text"/>
Name of Other Carrier(s):	<input type="text"/>
Address of Other Carrier(s):	<input type="text"/>

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**Section D Authorization to Release Medical Information**

(Cambridge Administrators herein referred to as the "Administrator")

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Berkley Life and Health Insurance Company, StarNet Insurance Company (Berkley), its authorized Administrator or their legal representative, and any agent acting on their behalf any such information. I understand that I may revoke this authorization at any time by providing written notice to Berkley or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by Berkley or its authorized Administrator. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request. I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law.

**Warning:** 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/or civil penalties. (Fraud language varies by state, for **New York** see the following, all other state specific states, please see below)

**For residents of New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant's Name: \_\_\_\_\_

Signature of Insured or Authorized representative: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Organization Official \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice to CALIFORNIA RESIDENTS** - please refer to following link for an important notice regarding the collection of Personal Information. <https://www.berkley.com/privacy#californiaCollectionAtNotice>

**FRAUD WARNING NOTICES**

**For residents of 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.

**For residents of 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.

**For residents of California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For residents of 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.

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**For residents of Delaware and Idaho:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

**For residents of Florida:** 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.

**For residents of Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**For residents of 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.

**For residents of 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.

**For residents of 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.

**For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**For residents of Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**For residents of 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.

**For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**For residents of New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**For residents of Ohio and Oklahoma:** 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.

**For residents of Oregon:** 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 a crime and may be subject to fines and confinement in prison.

**For residents of 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.

**For residents of Vermont:** Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law