



2018/19 Insurance Claim Form

If you are injured in an ISR sanctioned event, please complete this form to file a claim. Once complete return back to Nikki@usacracing.com, or USAC Racing PO Box 24575 Indianapolis, IN 46224.

***DO NOT WAIT FOR BILLS TO SUBMIT THIS FORM.
ALL CLAIMS MUST BE REPORTED IMMEDIATELY.
ALL CLAIMS PAST 90 DAYS WILL BE DENIED.**

Name _____

Annual Member# _____ Single Event Member

Date of Accident _____ Date Claim Received (office use) _____

Race Name/Location _____

Primary Insurance Name _____

I **DO NOT** have primary insurance

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

- Race Incident Report - **FILLED OUT BY RACE DIRECTOR**
- The attached Insurance Claim Form
- Copies of all itemized bills as they are received
- Copies of additional documents that support your claim.
- Copies of all primary insurance Explanation of Benefits (EOBS)

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



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



Instructions for Submitting a Blanket Accident Claim

1. This claim form must be submitted for each individual accident. 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 PO Box 24575, Indianapolis IN 46224 or may be emailed to: Nikki@usacracing.com. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident but must be submitted for each accident within 90 days of the occurrence.
2. Please ask your provider to submit all medical bills first to your primary insurance, then to Cambridge administrators. 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) and attach to the claim form for submission. A balance due or patient statement is not acceptable and will only delay processing.
3. 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 provider must first submit the claim to the primary insurance. After the primary insurance has paid benefits, the provider should submit the itemized bills along with the corresponding Explanation of Benefits (EOBs) directly to Cambridge Administrators.
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. The explanation of benefits form 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 claim has first been submitted to the primary health insurance coverage, 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 the initial information from Step 1 to:

Nikki@USACRacing.com
Or to: USAC Racing
PO Box 24575
Indianapolis IN 46224

Send all additional bills or information to:

Cambridge Administrators
5832 South 142nd St, Suite A
Omaha, NE 68137

Submit claim form and bills to:

Cambridge Administrators LLC
5832 South 142nd 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



Section A Claimant Information

Group / Policyholder Social Security No

Claimant Name Date of Birth / / Gender M/F

Claimant Address

Email Address Best contact phone number ()

Section B Accident Information

Accident Date (month / day / year) / / Type of Sport/Activity/Event

Location Injury Occurred to: Participant Official Crew Spectator Other _____

Type of injury (indicate part(s) of body injured - i.e., broken right arm, sprained left ankle, etc.)

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

Section C Other Coverage Information

Do you have other health insurance? YES NO If YES, complete below:

Policyholder Name (s):

Policyholder ID number(s):

Name of Other Carrier(s):

Address of Other Carrier(s):

Section D Authorization to Release Medical Information

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company, or its authorized Administrator or their legal representatives.

Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HI, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request.

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, please see below)

Signature of Insured or Authorized representative: _____ Date: _____

Signature of Organization Official _____ Title: _____ Date: _____

FRAUD WARNING NOTICES

For residents of Alaska, 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 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 a 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.

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.

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 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.

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

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 Delaware - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.