2560 River Park Plaza, Suite 300
Fort Worth, Texas 76116
(866) 738-6100 Fax (817) 738-2993
PullenIns.com

OHIO SOUTH YOUTH SOCCER ASSOCIATION
ACCIDENT MEDICAL CLAIM FORM

GUIDELINES FOR SUBMITTING A YOUTH SOCCER ACCIDENT CLAIM FORM

1. Complete **ALL** questions on the Youth Soccer Accident Claim Form.
2. Have the coach or another local official that witnessed the accident sign **Section III** (COACH OR LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in **Section VI** (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)
4. File this new report of claim within 90 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have other insurance, submit your itemized bills to the other carrier first. You will receive a payment Explanation of Benefit worksheet (EOB) from your other carrier. Do **NOT** wait until your other carrier has processed all your bills before filing a Youth Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to your State Association for verification and authorized state signature. **DO NOT SEND THE CLAIM FORM DIRECTLY TO PULLEN INSURANCE SERVICES.**
8. Upon receipt of the claim form from your state association we will forward an acknowledgement form advising you of receipt of your claim. All future correspondence concerning your claim should be directed to Mutual of Omaha at the address and phone number listed on your acknowledgement.

HELPFUL REMINDERS

1. There is a $2,500 deductible per covered accident for the 9/1/15 - 9/1/16 policy year. Each claim is also subject to the application of an 80/20 co-insurance provision with a $50 physical therapy/chiropractic limit per visit/$2,000 total maximum. **Failure to follow the rules of your primary healthcare coverage will result in a benefit reduction of eligible expenses to 50% of the amount otherwise payable.**
2. Each itemized bill MUST show the following:
   - Provider of Service's Name
   - Provider's Address
   - Provider's Federal Tax ID#
   - Provider's Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-9)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure
3. Additional bills to be submitted at a later date (after the initial submission of your claim) should be mailed directly to Mutual of Omaha with the following information: Name of the claimant, date of the accident, and name of the State Youth Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Parent / Guardian / Claimant's responsibility to request this information from the provider of service or from your primary carrier.
6. An Explanation of Benefits will be sent to you by Mutual of Omaha.

MOST FREQUENTLY ASKED QUESTIONS

What is an itemized bill?

An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

What if I don't have an itemized bill?

The Parent/Guardian must request this information from the provider of service. Some providers only mail a balance due statement. Mutual of Omaha, is unable to process this charge without an itemized bill. Again, request this information from the provider service. Explain that you have Youth Soccer Excess Accident Coverage.

Can you process this claim with my other insurance carrier's worksheet alone?

No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

What if I don't have my other carrier's payment explanation (EOB)?

The Parent/Guardian must request the EOB from their other insurance carrier.

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Policy Number:
SR2014OH-P-053084

Policy Year: 9/1/15 – 9/1/16

IMPORTANT
This claim form must be mailed to your state association listed below:

Ohio South Youth Soccer Association
25 Whitney Drive, #104
Milford, OH 45150

SECTION I TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

1. Name: (LAST)_____(FIRST)_____(MIDDLE) _____
2. Date of birth: _____ / _____ / _____ 3. Sex: ☐ Male ☐ Female
4. Home Address: (STREET)_____
   (CITY) _____ (STATE) _____ (ZIP CODE) _____
5. Type of claimant: ☐ Player ☐ Coach/Asst Coach ☐ Other: _____
6. Accident date: _____ / _____ / _____
7. Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): _____
   _____
8. Did accident occur during (✓ all that apply) ☐ game ☐ practice ☐ tournament ☐ indoor soccer
   ☐ sanctioned/sponsored activities ☐ travel directly and interruptedly to or from activity premises
9. Describe how and where accident occurred: _____
   _____
10. Name of field / facility where accident occurred: _____

SECTION II STATISTICAL INFORMATION

1. Name of local association or league: _____
2. Name of club (if applicable): _____ 3. Name of team: _____
4. Age Division: (U-12, U-10, etc): _____ 5. ☐ Competitive ☐ Recreational

6. Time:	☐ Morning	☐ Afternoon	☐ Evening	☐ After Hours
7. Location:	☐ On Field	☐ Sidelines	☐ Spectator Area	☐ Other
8. Disposition:	☐ On-site Care Only	☐ Ambulance	☐ Personal transportation	☐ Refused care
9. Surface:	☐ Dirt	☐ Grass	☐ Artificial Turf	☐ Other
10. Surface condition:	☐ Dry	☐ Wet	☐ Icy	☐ Irregular
11. Position:	☐ Goalie	☐ Forward	☐ Defender	☐ Other
12. Activity:	☐ Running w/ ball	☐ Running w/o ball	☐ Defending	☐ Other
13. Situation:	☐ Hit by ball	☐ Collision w/ Participant	☐ Non-contact injury	☐ Other

SECTION III COACH OR LOCAL OFFICIAL VERIFICATION

Signature of Coach or Local Official	Coach or Local Official Name (print)	Date

SECTION IV AUTHORIZED STATE OFFICIAL *

I, _____, of the _____ certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

Signature of Authorized State Official	Title	Date

* Must be signed by the authorized state soccer association administrator with the state soccer office.

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CLAIMANT'S NAME: _____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

SECTION V PARENT / GUARDIAN / CLAIMANT INFORMATION

Father / Guardian / Claimant	Mother / Guardian / Claimant
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Home Phone: (_____) _____ - _____	Home Phone: (_____) _____ - _____
Employer: _____	Employer: _____
Phone: (_____) _____ - _____ Ext. _____	Phone: (_____) _____ - _____ Ext. _____
Email: _____	Email: _____

Is claimant covered under ANY other insurance policy? ☐ Yes ☐ No

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____

Insured Name: _____

Insured ID #: _____ Insured Group # / Name: _____

If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party: _____

_____

SECTION VI STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION

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.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent / Guardian / Claimant Date

SECTION VII ASSIGNMENT OF BENEFITS

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

Coverage Underwritten by: Mutual of Omaha