MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

MCA Administrators, Inc. (MCA)

Formerly DIVERSIFIED GROUP ADMINISTRATORS (DGA)

P.O. BOX 6540 • HARRISBURG, PA 17112

ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS

CLAIM ASSISTANCE:
1-800-427-9308

STUDENT STATEMENT

STUDENT NAME	SOCIAL SECURITY NUMBER	NAME OF COLLEGE/UNIVERSITY

ADDRESS	CITY	STATE	ZIP	TELEPHONE SCHOOL	TELEPHONE HOME

PATIENT (IF OTHER THAN STUDENT)	MALE ☐ FEMALE ☐	PATIENT RELATIONSHIP TO STUDENT	PATIENT BIRTH DATE

DATE ACCIDENT OR SICKNESS BEGAN	NATURE OF SICKNESS OR INJURY	DID ACCIDENT HAPPEN AT SCHOOL? ☐ YES ☐ NO

IF AN INTERCOLLEGIATE SPORTS ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT
I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

SIGNATURE: TITLE: DATE:

NAME OF SPORT	TYPE OF SPORT ☐ CLUB ☐ INTRAMURAL ☐ INTERCOLLEGIATE	PART OF BODY INJURED

GIVE NAME, ADDRESS AND TELEPHONE NUMBER OF PHYSICIAN

HAVE YOU BEEN TREATED BEFORE FOR SAME CONDITION?

☐ YES ☐ NO IF YES, when By whom

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THESE EXPENSES OF THIS CLAIM? ☐ YES ☐ NO

NAME OF COMPANY

FATHER'S NAME	FATHER'S EMPLOYER	NAME	ADDRESS
MOTHER'S NAME	MOTHER'S EMPLOYER	NAME	ADDRESS
SPOUSE'S NAME	SPOUSE'S EMPLOYER	NAME	ADDRESS

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Company or Administrator. A photostatic copy of this authorization shall be as valid as the original.

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 purposes of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime.

X ______________________________

SIGNATURE OF INSURED OR PARENT (IF MINOR) DATE

INSTRUCTIONS AND PROCEDURE FOR FILING A CLAIM

I. Complete the "Student Statement" part of the claim form.
- **A. Make sure you identify your college or university.**
- **B. It is important to know when, how and where your accident or illness began.**
- **C. Questions regarding other coverage you or your dependents are eligible for must be answered.**
- **D. Patient or parent (if patient is a minor) must always sign the Authorization to Release Information section.**

II. Make a final check to see that all parts of the claim form are complete.

III. If you have other coverage make sure you attach all payment statements or denial letters.

IV. Attach all medical bills relating to the claim.
- **A. Make sure all bills identify patient.**
- **B. All bills should show date of treatment, type of service, and amount of charges.**

PAYMENT WILL BE MADE TO THE SOURCE OF SERVICES (HOSPITAL, PHYSICIAN, ETC.) UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.