

(NOTE: Report and Claim Form will be returned if not fully completed and signed.)

Basic Procedures for Submitting Case Report and Accident Insurance Claim Form

1. The participant or participant's parents/guardian should complete pages 2 and 3 of the form, and forward it to:
K&K Insurance - Claims, PO Box 2338, Ft. Wayne, IN 46801.
2. A completed First Report of Occurrence form should accompany this form.
3. A race official must validate your first report of occurrence form to avoid delays in the processing or handling of your claim.

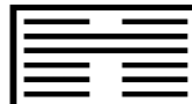
To the Athlete/Parent/Guardian/Volunteer

Attach current itemized physician, hospital or other provider's bills for accident medical expenses claimed as well as the primary carrier's Explanation of Benefits showing payments and denials. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made.

K&K INSURANCE GROUP, INC. / SPECIALTY BENEFITS, INC.
Claims Department
P.O. Box 2338
Fort Wayne, Indiana 46801-2338
(800) 237-2917



The
First Health
Network



HYGEIA

Instructions for Completing the Accident Insurance Form to the Injured Person/Parent/Guardian

To the injured person/parent/guardian: Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Return this form to K&K Insurance Group, Inc. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.

Applicable in 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.

Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia

Any person who knowingly and with intent to defraud any insurance company or another 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, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied.

Applicable in 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

Applicable in Florida and Idaho

Any person who knowingly and with the intent to injure, defraud, or deceive

any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.*

* In Florida - Third Degree Felony

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in 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.

Applicable in Minnesota

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

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with 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.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she 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.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

1712 Magnavox Way, P.O. Box 2338
Fort Wayne, Indiana 46801-2338
Phone: 800-237-2917
Fax (312) 381-9077

ON BEHALF OF NATIONWIDE INSURANCE

USA Cycling
Case Report
For registered
Cyclists/Officials/Volunteers



PLEASE REMEMBER

- You must return this form to:**
*USA Cycling, c/o K&K Insurance Group – Claims Dept.,
1712 Magnavox Way, P.O. Box 2338,
Fort Wayne, IN 46801-2338.*
- Do **NOT** take this form to your medical provider for completion: **YOU MUST FILL IT OUT.**
- YOU MUST SIGN** this form.
- We **MUST** have a copy of your USA Cycling membership card to process your claim.
- USA Cycling Insurance is an excess policy and may carry a **DEDUCTIBLE**.
- Keep a copy for your files.

(Mark all that apply. Complete relevant blanks.)

Date of Incident: _____ Time of Incident: _____ Date of Event: _____
 Was the injured person riding: Single Bike Tandem Bike
 USAC License Number: _____
 Does the injured person have medical insurance? Yes No
 If Yes, name of insurance company and policy.
 Insurance company name: _____ Policy name: _____
 Race Name: _____ Permit Number#: _____
 Promoter's Name: _____ Promoting Club: _____

INJURED PERSON INFORMATION:

Participant Volunteer Official Other: _____
 Was the injured person wearing a helmet at the time of the accident? Yes No
 Annual License Rider One Day Rider
 Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (_____) _____ Social Security #: _____
 Age: _____ Date of Birth: _____ Gender: Male Female
 Employer's Name: _____

TYPE OF EVENT

- USCF - Road
- NORBA - Mountain
- USPRO-Track
- NCCA - Collegiate
- BMX (BMXA)
- Cyclocross

CATEGORY

- 1
- 2
- 3
- 4
- 5
- Pro

ROAD TYPE

- Paved
- Dirt
- Gravel
- Asphalt
- Off-Road

INCIDENT LOCATION

- Off-Road
- Parking lot
- Registration area
- Restroom/locker room
- Premises/grounds
- Street
- Highway
- Rural road
- Off property
- Velodrome/track

RIDER ACTIVITY

- Turning right
- Turning left
- Being passed
- Passing
- Intersection
- Straight

ROAD CONDITIONS

- Wet
- Dry
- Ice

CAUSE

- Assault
- Fall
- Caught in extremity
- Animal involvement
- Collision (with parked car)
- Collision (with moving car)
- Collision (with object)
- Collision (with participant)
- Collision (with pedestrian)
- Auto/property (with parked car)
- Overexertion
- Equipment malfunction

DISPOSITION

- Report only
- Released to parent
- Police
- Ambulance to hospital
- Refer to doctor
- Refer to hospital/clinic
- First Aid
- Continued riding
- Refused treatment

PRIMARY INJURY

- | | | | | |
|--------------------------------------|--|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Death | <input type="checkbox"/> Amputation | <input type="checkbox"/> Abrasion | <input type="checkbox"/> Burn |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Concussion | <input type="checkbox"/> Heat exhaustion | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Nausea | <input type="checkbox"/> Electrical shock | <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Contusion |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Drowning | <input type="checkbox"/> Pain | <input type="checkbox"/> Illness | <input type="checkbox"/> Insect bite |
| | <input type="checkbox"/> Strain/Sprain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Frostbite | <input type="checkbox"/> Other: _____ |

BODY PART INJURED

- | | | | | | |
|--|--|---|--------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Eye (L) (R) | <input type="checkbox"/> Hand (L) (R) | <input type="checkbox"/> Shoulder (L) (R) | <input type="checkbox"/> Head | <input type="checkbox"/> Torso | <input type="checkbox"/> Tooth |
| <input type="checkbox"/> Ankle (L) (R) | <input type="checkbox"/> Arm (L) (R) | <input type="checkbox"/> Foot (L) (R) | <input type="checkbox"/> Face | <input type="checkbox"/> Internal | <input type="checkbox"/> Ear (L) (R) |
| <input type="checkbox"/> Knee (L) (R) | <input type="checkbox"/> Hip (L) (R) | <input type="checkbox"/> Leg (L) (R) | <input type="checkbox"/> Mouth | <input type="checkbox"/> Back | <input type="checkbox"/> Finger or Toe |
| | <input type="checkbox"/> Wrist (L) (R) | <input type="checkbox"/> Elbow (L) (R) | <input type="checkbox"/> Neck | <input type="checkbox"/> Nose | <input type="checkbox"/> Other: _____ |

DESCRIBE HOW THE INCIDENT HAPPENED: _____

Signature of injured party: _____ Date: _____
 Phone: (_____) _____ Fax: (_____) _____ Email: _____



USA CYCLING ACCIDENT MEDICAL INSURANCE CLAIM FORM

PLEASE NOTE: If Injured Person is a Minor, we must have BOTH parents' information. If the injured person is married, we must have the spouse's information or mark area N/A.

**IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THIS CLAIM FORM BE PROVIDED.
OMISSION OF VITAL INFORMATION WILL CAUSE DELAY IN CLAIM PROCESSING.**

TO BE COMPLETED BY INJURED PERSON OR PARENT

COVERAGE UNDER THE POLICY IS EXCESS OVER ALL OTHER VALID AND COLLECTIBLE HEALTH AND ACCIDENT PLANS. YOUR CLAIM SHOULD BE SUBMITTED TO THE INSURANCE COMPANY PROVIDING COVERAGE TO YOU THROUGH YOUR OWN, YOUR PARENTS' OR YOUR SPOUSE'S HEALTH PLAN, YOUR EMPLOYER OR GOVERNMENTAL HEALTH PLAN. AFTER OTHER INSURANCE BENEFITS HAVE BEEN SUBMITTED, YOU SHOULD FORWARD A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS AND THE CORRESPONDING ITEMIZED MEDICAL STATEMENTS. IF YOUR INSURANCE COMPANY DENIES BENEFITS, SEND A COPY OF THEIR DENIAL. IF THERE IS NO OTHER VALID AND COLLECTIBLE INSURANCE, THIS POLICY WILL ACT AS PRIMARY INSURANCE. **FURTHER DETAILS OF COVERAGE WILL BE COMMUNICATED TO YOU UPON RECEIPT OF THIS FULLY COMPLETED CLAIM FORM.**

WE WILL NOT PROCESS YOUR CLAIM WITHOUT EMPLOYER INFORMATION. THE DATA REQUESTED IS IMPERATIVE AND WILL EXPEDITE YOUR CLAIM PROCESSING.

Insured Person's Name: _____ Spouse's Name (If applicable.): _____

Father's Name (If minor.): _____ Mother's Name (If minor.): _____

Social Security No.: _____ Social Security No.: _____

Employer's Name: _____ Employer's Name: _____

Employer's Address: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ Policy No.: _____ Phone: _____ Policy No.: _____

Group Insurance Company: _____ Group Insurance Company: _____

Insurance Company's Address: _____ Insurance Company's Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

I certify that this injury occurred to a USA Cycling registered member during a USA Cycling sanctioned event and the above information is true and accurate to the best of my knowledge and belief, and I understand fraudulent statements can be a crime.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K INSURANCE GROUP, INC., SPECIALTY BENEFITS, INC. OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY PRIMARY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY PRIMARY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF PROPER INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

Signature: _____ Date: _____

PLEASE NOTE: If Injured Person is a Minor, signature must be of Parent or Legal Guardian.



Standard Medical Authorization Request Form

— to be completed by the medical provider —

All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned. Please fax completed form to: 312-381-9077

Claimant Name: _____ Date of Birth: _____

Claim #: _____ Date of Injury: _____

Requesting Physician: _____

Requesting Provider: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Contact: _____

Contact: _____

DX	HCPCS/CPT	DESCRIPTION OF ITEM/SERVICE	BODY PART	SELECT ONE	DATE OF SERVICE	
				<input type="checkbox"/> Right <input type="checkbox"/> Left	BEGIN	END
				<input type="checkbox"/> Right <input type="checkbox"/> Left		
				<input type="checkbox"/> Right <input type="checkbox"/> Left		
				<input type="checkbox"/> Right <input type="checkbox"/> Left		

Date Request Submitted: _____ New Request Revised-Request

Please Select One:

- Authorization Approved
- Authorization Denied
- Authorization Pending
- Modified Authorization

Comments: _____

Signature: _____ Date: _____

K&K Consultant

Further as permitted by applicable law, this pre-authorization is subject to concurrent review as to medical necessity, appropriateness of efficacy, and coverage for services being provided. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and payment. All medical services must be authorized by K&K Consultant above prior to treatment.

In absence of authorization, silence is acceptance of an offer of payment of 100 % of CMS Medicare payment policies of state of filing and reduction of all complex and very complex CPT codes to simple to moderate CPT codes.

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential, proprietary, and privileged information. This information is intended only for the use of the individual(s) named above. Any unauthorized review, use, disclosure or distribution is prohibited.