NAHGA Claim Services

National Accident & Health General Agency, Inc.
P.O. Box 189
Bridgton, ME 04009-0189
(800) 952-4320

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Member Name: _____

SSN: _____

DOB: _____

Policy: _____

Adjuster: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

   ___ Problem/Diagnosis History

   ___ Medical Bills submitted to NAHGA for payment by student insurance

   ___ Payments made by NAHGA on my behalf through student insurance

   ___ Any other pertinent information relating to the payment/processing of my medical claims

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to the following individuals or organization(s):

   Name: _____

   Address: _____

   _____

5. This information for which I'm authorizing disclosure will be used for the following purpose:

   Processing/Payment of Health Insurance Claims by NAHGA Claim Services

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to NAHGA, Inc. I understand that revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization shall expire on (insert date or event): _____
   If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure payment of healthcare claims.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

Distribution of copies: Original to NAHGA, Inc., copy to patient; copy to accompany use or disclosure.

Please print or type. Incomplete forms will be returned.
SEND COMPLETED FORM & BILLS TO:

PRINT FORM

CLEAR FORM

SUBMIT ONLINE

NAHGA CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

NAHGA Claim Services
P.O. Box 189
Bridgton, Maine 04009-0189
(800) 952-4320
(207) 647-4569 Fax

IMPORTANT NOTICE:
The student insurance plan is designed to provide maximum benefits for minimum premium. If you have other medical insurance, you must submit this claim to your other carrier first. When you receive their Explanation of Benefits, send it to us with the corresponding itemized bills.

If this form is not completed in FULL, this claim cannot be processed and will be returned.

PART 1: POLICYHOLDER & INSURED

(1) School/Organization: Marin CCD

(2) Policy Number: PSR100110

(3) Student - Last Name, First Name

(4) Student Social Security Number

(5) Mailing Address where Insurance Info/Requests should be mailed

(6) City, State, Zip

(7) Phone

(8) Birthdate

(9) Male ❑ Female ❑

(10) Was a Pre-Participation Physical performed clearing athlete for participation? Yes ❑ No ❑

(11) Date & Time of Injury

(12) Where did injury occur?

(13) How did injury occur?

(14) Part of body injured

(15) Date of first medical treatment

(16) Is this condition: Acute Injury ❑ or Chronic/Overuse Condition ❑

(17) Has health history been recently reviewed by sports medicine staff? Yes ❑ No ❑

(18) Has the athlete injured the same body part in the past? Yes ❑ No ❑

(if yes, please attach a copy of the pre-participation physical showing clearance)

(19) Sport Type: _____ Designation: Intramurals ❑ Practice ❑ Game ❑ Other ❑ _____

(20) Was the Student involved in an activity sponsored and supervised by the school at the time of injury? Yes ❑ No ❑

(21) Under whose supervision? Was He/She a witness? Yes ❑ No ❑

(22) Signature of Supervisor/Official: Title Date

PART 2: PARENT OR GUARDIAN STATEMENT

(1) Father/Guardian Name Telephone	(2) Mother/Guardian Name Telephone
(3) Home Address (Street, City, State, Zip)	(4) Home Address (Street, City, State, Zip)
(5) Employer	(6) Employer
(7) Father's Employer Address (Street, City, State, Zip)	(8) Mother's Employer Address (Street, City, State, Zip)
(9) Business Phone	(10) Business Phone

(11) Is Student covered by any other insurance policy (other than this school policy), either as a dependent, group, individual, automobile medical or liability? Yes ❑ No ❑

If yes, please list name of insurance carrier: _____

Please note that if other insurance exists, all claims must be submitted to that other insurance policy first.

PART 3: AUTHORIZATION

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Student to disclose when requested to do so, any information to NAHGA CLAIM SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. I understand this information will be utilized for the purpose of claim administration and agree that there are no specified limitations. This authorization shall be valied for 102 weeks. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.

X _____ _____

Signature of Student or Authorized Person Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

X _____ _____

Signature of Student or Authorized Person Date

Note: If you do not sign the authorization to pay benefits to the provider and would like payment made directly to you, you MUST submit paid receipts for each bill. V.03.16