Accident, Sickness, Heart Attack/Heart Disease/Stroke

Underwritten by: Atlanta International Insurance Company
Administered by: Bay Bridge Administrators LLC

Claim Filing Instructions

Page 1 – Insured's Statement of Claim:

Must be completed each time you file a claim. Be sure to answer every question. If filing a claim due to accident/injury where a police report was filed, a copy of the police report must be included with claim.

Page 2 – Authorization

Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to Bay Bridge Administrators, LLC

Pages 3 & 4 – Pre-existing Review Form

If claim is being filed within the first two years of the policy, please complete this page with all physicians seen or medications taken in the past 24 months.

If provider fax numbers are known, please provide them in order to expedite this process. Please make certain authorization is signed and dated.

Pages 5 - Employer's Statement

If you are filing for total disability benefits under the accident policy, this form must be completed by your Employer representative.

Pages 6 & 7 - Physician's Statement

To be completed by your treating Physician. If treated in an emergency room, the admit and discharge summary may be submitted in lieu of this form.

Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes and corresponding Explanation of Benefits statement from the primary health insurance.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation by mail or fax to:

Bay Bridge Administrators, LLC
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

Claim Form for Accident, Heart Attack/ Heart Disease & Stroke	**Underwritten by: Atlanta International Insurance Company** **Administered by: Bay Bridge Administrators, LLC** **PO Box 161690** **Austin TX 78716** **800-845-7519**

INSURED'S STATEMENT OF CLAIM

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address:		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:

Illness or Injury for which claim is being made:	Date of Accident or date Illness was first diagnosed:	Date you were first treated for your Illness or Injury:

Describe the onset and nature of your Illness or Injury:

Have you ever had the same or a similar condition in the past? __Yes __No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? __Yes __No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address

Only complete the following portion if covered by and applying for Disability benefits under the optional rider on the Accident Policy

6. Between what dates were you totally and continuously disabled? From _____ to _____

7. Between what dates were you partially disabled? From_____ to _____

8. If still disabled, when do expect to resume full duties?_____

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 fines and confinement in prison.

Signature of Insured_____

Date _____

The above Statements are true to the best of my knowledge and belief

AUTHORIZATION
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.
3. I authorize only designated staff of Bay Bridge Administrators, LLC. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, LLC. This revocation shall become effective on the date it is received by Bay Bridge Administrators, LLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

_____ _____ _____

Signature Print Name Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____

Name of Authorized Representative Relationship to Applicant Date

Parent or Guardian*A copy of the legal authority document must be on file with Bay Bridge Administrators, LLC

If claim is being filed during the first two years of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last 5 years:

Physician's Name:

Address:

Telephone Number: Fax Number:

Approximate Date Consulted: Diagnosis:

Physician's Name:

Address:

Telephone Number: Fax Number:

Approximate Date Consulted: Diagnosis:

Physician's Name:

Address:

Telephone Number: Fax Number:

Approximate Date Consulted: Diagnosis:

Physician's Name:

Address:

Telephone Number: Fax Number:

Approximate Date Consulted: Diagnosis:

Physician's Name:

Address:

Telephone Number: Fax Number:

Approximate Date Consulted: Diagnosis:

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

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 subject to prosecution and punishment for insurance fraud.

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Employer's Statement

To be completed by Employer		
Employee's Name:	SSN:	Date of Birth:
Date last worked or placed on light duty status: _____ Reason for stopping work: _____ _____ Is employee's job being held open?	Has Employee returned to regular work status? Yes ☐ No ☐ If yes, full-time date: _____ Part-time date: _____	
Name and Address of Employer:		
Employer Signature	Date Signed	
Printed Name and Title	Employer's Telephone Number	
E-mail address	Fax Number	

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Austin TX 78716
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Physician's Statement

To be completed by the Medical Provider		
Claimant Name	Date of Birth	
Diagnosis	ICD-10 Code	Date of Diagnosis
Date Disability Commenced __/__/____		
Is condition due to injury or sickness arising out of patient's employment? Yes □ No □	Dates of Treatment Date of first visit __/__/_____ Date of last visit __/__/____	Frequency of treatment Weekly □ Monthly □ Other
Has patient been hospital confined for this condition? Yes ☐ No ☐ If yes, please list name of hospital and dates:		
Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes □ No □		
If yes, Diagnosis:	Dates of Treatment	Name and address of Referring Physician:
Nature of Treatment – please describe course of treatment:		
Progress: (a) prognosis with reasonable estimate of return to work date		
Medical Provider's Name (Please Print)	Phone Number	Fax Number
Limitations (what the patient CANNOT do)		

Physical Impairment *as defined in Federal Dictionary of Occupational Titles)	☐ **Class I – No limitation of functional capacity; capable of heavy work *no restrictions (0-10%)** ☐ **Class 2 – Medium manual activity *(15-30%)** ☐ **Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%)** ☐ **Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)** ☐ **Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)**	
Remarks:		
Medical Provider's Signature	Date Signed	
Name of Physician (Please Print)	Telephone Number	Fax Number
Mailing Address		

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