

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS AND PRIMARY CARRIER EXPLANATION OF BENEFITS
3. MAIL TO HSR

E-mail : RODEO@HSRI.com



8400 Belleview Drive, Suite 150
Plano, Texas 75024
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (877) 534-7669



Policy Number: **T5MP-P-052380**

PROFESSIONAL RODEO COWBOYS ASSOCIATION

1. Claimant's Name (Injured Person)	2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Injured Person				7. Cell Phone Number
8. (If Minor) Parent/Legal Guardian Name, Address, City, State & Zip				9. Parent's Phone Number
10. Date of Accident	11. Date of First Treatment & Name of Physician			12. Did Injury Result in Death? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Place Where Accident Occurred (Name of Town, Area, and Event You Were Participating in When Injury Occurred)				
14. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc. – Specify Left or Right When Applicable)				
15. Describe How Accident Occurred – Give All Possible Details – Must Be A Bodily Injury Due to Accident				

OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ YES ☐ NO

* If Yes, name of insurance company _____

Policy # _____

Name of insurance company _____

Policy # _____

Claimant's primary employer name, address, and phone number _____

Mother's primary employer name, address, and phone number _____

Father's primary employer name, address, and phone number _____

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT
X _____

DATE _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (if not signed, submit proof of payment)

SIGNATURE X _____

DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE X _____

DATE _____

PRCA OFFICIAL VERIFICATION

* I hereby verify that the above member participated in the _____ rodeo or Sanctioned Practice on (Date) _____ during which the injury allegedly occurred.

PRCA JUDGE'S SIGNATURE X _____

DATE _____

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD WARNING NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of 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.

STATE SPECIFIC PROVISIONS

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
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.
Arkansas	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.
Louisiana	
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
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 policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder or claimant, with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Idaho	
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer, for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
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.
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.
Kentucky	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 purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Michigan	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 and subject the person to criminal civil penalties.
North Dakota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
South Dakota	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
Minnesota	
Nevada	Any person who, with a 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.
New Hampshire	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Jersey	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 civil fines and criminal penalties.
New Mexico	
New York	Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Ohio	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.
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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.
Rhode Island	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.
West Virginia	
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Virginia	
Washington	
Texas	Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

How to File Your Claim and Important Tips

YOUR CLAIM FORM

1. Your claim form should be fully completed and submitted within 90 days from the date of injury.
 - a. Be sure to provide your **email address** and **cell phone number** so that we may, if needed, contact you while away from home. **You may receive a text message from 972-645-9092 if we are unable to reach you via a phone call.**
 - b. Fully complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either Yes or No, sign and date.
 - c. Sign and Date both lines under “**AUTHORIZATION TO PAY BENEFITS TO PROVIDER**”. This will ensure that HSR and your doctors/hospital may communicate directly concerning your claim.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records and submit to HSR via email, fax or USPS mail. Mailing information can be found at the top of the claim form.
4. DO NOT assume that anyone else will mail this claim form to HSR for you.

YOUR BILLS

1. Please be sure and advise all doctors/hospitals of this coverage so they will provide itemized bills to us.
2. **If you have already been treated by a doctor/hospital and did not know about this coverage, then please send all your itemized bills to HSR.** (An itemized bill is usually in the HCFA-1500 or UB-04 format) See attached examples.
3. The bills should include the name of the doctor/hospital, their complete mailing address, their Tax Identification Number (TIN), telephone number, the date you were treated by the doctor/hospital, the diagnosis codes and the specific itemized charges incurred. Also known as CPT codes.
4. If this information is not on the bills that are sent in to HSR, it will delay the handling of your claim. “Balance Due” statements do not contain sufficient information to complete your claim.

EXCESS OR OTHER INSURANCE

1. Your coverage through the PRCA pays on a secondary/excess basis. If you have any other primary insurance, you need to send the bills to your primary insurance first.
2. HSR will consider benefits after your other, primary insurance has processed the claim.
3. You will need to send to HSR a copy of the Explanation of Benefits (EOB) you received from your primary insurance showing what was paid or denied, and the reason for denial. Due to HIPAA regulations HSR is unable to obtain this information from your primary insurance carrier on your behalf.
4. HSR will not be able to consider your claim without this information.

If you have any questions, please contact Debra Black, Customer Service Manager at (877) 534-7669. Debra is available from 8:00 a.m. to 5:00 pm Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820, via email to Rodeo@hsri.com or via USPS to:

Health Special Risk, Inc.
8400 Bellevue Drive, Suite 150 Plano, TX 75024

Sample UB04 Form

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Sample CMS 1500 Form

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