ACCIDENT CLAIM FORM

ALL CLAIMS OR LOSS NOTIFICATIONS MUST BE FILED WITH MCS LIFE INSURANCE COMPANY WITHIN TWENTY (20) DAYS FOLLOWING THE DATE OF THE ACCIDENT. THE PHYSICIAN, DENTIST, OR HOSPITAL ATTENDING THE PATIENT MUST COMPLETE THE REPORT ON THE BACK OF THIS FORM. SECTION I MUST BE COMPLETED BEFORE THE INJURED PERSON TAKES IT TO THEIR DOCTOR.	**REQUIRED BASIC DOCUMENTS:** ❑ Progress notes from the emergency room visit ❑ Progress notes from the physician who attended after the accident ❑ Studies and/or laboratory tests results ❑ Operation report ❑ Payment receipts properly identified with the patient's name, date of service, ICD-10 codes, CPT codes, and amount paid by the patient ❑ Additional documents may be required **Note:** Send documents via e-mail: segurodevidacommercial@medicalcardsystem.com

SECTION I – INSURED INFORMATION (PLEASE WRITE IN PRINT)

1. INSURED'S FULL NAME (injured person):			2. SOCIAL SECURITY NUMBER:
3. DATE OF BIRTH (month/day/year):	4. AGE:	5. GENDER:	6. PHONE NUMBER:
7. POLICY NUMBER:			
8. MAILING ADDRESS:			
9. DATE OF ACCIDENT:	10. TIME OF ACCIDENT:	11. HOW DID THE ACCIDENT OCCUR? (Describe in detail):	
12. PLACE WHERE THE ACCIDENT OCCURRED:		13. POLICYHOLDER'S NAME (insured entity):	
14. POLICYHOLDER'S ADDRESS (insured entity):			
15. INDICATE IF THE INSURED HAS OTHER HEALTH INSURANCE PLAN: ❑ Yes ❑ No		16. IF SUCH PLAN WAS USED, PLEASE INDICATE NAME:	

- ANTI-FRAUD NOTICE-

Any person who knowingly and with intent to defraud presents false information in an insurance application or who submits, assists, or causes to submit a fraudulent claim for payment of a loss or other benefit, or submits more than one claim for the same damage or loss, commits a felony and, upon conviction, shall be punished for each violation with a fine of not less than five thousand (5,000.00) dollars nor more than ten thousand (10,000.00) dollars or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances exist, the fixed penalty may be increased up to a maximum of five (5) years; if mitigating circumstances exist, it may be reduced to a minimum of two (2) years.

Certification and/or authorization: I certify that all information provided by me in this form is true. I understand that the law imposes severe penalties, such as fines, imprisonment, or both at the discretion of the court, for providing false information with the purpose of obtaining insurance benefits. I authorize all physicians, hospitals, and other institutions that attended to me, my spouse, or my dependent children to provide **MCS LIFE INSURANCE COMPANY** any information relevant to this request. I authorize my employer to provide **MCS LIFE INSURANCE COMPANY** any necessary information or documents to determine my benefits.

NAME OF THE INSURED (Write in print)

INSURED SIGNATURE

TITLE

DATE

SECTION II – ATTENDING PHYSICIAN'S REPORT (PLEASE WRITE IN PRINT)

1. PATIENT'S FULL NAME:	2. AGE:	3. GENDER:

4. NATURE OF THE INJURY AND ICD-10 DIAGNOSIS (describe complications, if any):

5. IF A FRACTURE OR DISLOCATION OCCURRED, INDICATE WHETHER IT WAS: ❑ COMPLETE ❑ INCOMPLETE

6. IF A FRACTURE OF LONG BONES OCURRED, INDICATE TYPE AND LOCATION:	7. WAS IT CONFIRMED BY X-RAY? ❑ Yes ❑ No

8. HOW DID THE ACCIDENT OCCUR AND/OR WHEN DID SYMPTOMS FIRST APPEAR? DATE (month/day/year):

9. WHEN WAS THE FIRST MEDICAL EXAMINATION OF THE PATIENT FOR THIS CONDITION? DATE (month/day/year):

10. DOES THE PATIENT HAVE OR HAD ANY MEDICAL HISTORY OR CONDITIONS SIMILAR TO THE PRESENT CONDITION? ❑ Yes ❑ No

11. IF YES, DESCRIBE THE CONDITION, INDICATE DATE, NAME AND ADDRESS OF THE HOSPITAL OR PHYSICIAN WHO TREATED THE PATIENT:

12. DESCRIBE ANY OTHER DISABILITY OR MEDICAL CONDITION AFFECTING THE CURRENT ILLNESS OF THE PATIENT:

Any person, including an insurance agent, broker or solicitor, physician or any other health service provider, or an employer, who makes, assists, or participates in making a false representation of facts or submits incomplete information, knowing that the information is not true, to include in an insurance application or in a report or statement (claim) related to such insurance, may be considered to have committed fraud for purposes of the Insurance Code. (See Article 27.190 of the Insurance Code)

DESCRIBE TREATMENT, DATE, PLACE, AND CHARGES INCURRED BY THE PATIENT

DATE	PLACE	TREATMENT	CPT CODE	DEDUCTIBLE PAYMENTS
a.				
b.				
c.				
d.				
e.				
f.				

IF SURGERY WAS NECESSARY, PLEASE DESCRIBE IN DETAIL

DATE	PLACE	SURGICAL PROCEDURE	CPT CODE	DEDUCTIBLE PAYMENTS
a.				
b.				
c.				

13. IF THE PATIENT WAS HOSPITALIZED, PLEASE INDICATE (month/day/year):	ADMISSION DATE:	DISCHARGE DATE:

14. NAME OF THE HOSPITAL WHERE ADMITTED:

15. INDICATE IF THE INSURED USED ANOTHER HEALTH PLAN: ❑ Yes ❑ No IF YES, INDICATE NAME OF THE PLAN:

16. PHYSICIAN'S NAME:	17. LICENSE NUMBER:	18. SPECIALTY:

19. PHYSICIAN'S MAILING ADDRESS:

PHYSICIAN'S SIGNATURE _____ DATE _____ OFFICE PHONE _____