Preferred Plan
"The Network of Choice."

HSR
Health Special Risk, Inc.

MultiPlan Call 800-557-6794 for Facilities Referral

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO ⟶

E-mail: claims@hsri.com

HSR Plaza
4001 N. Josey Lane
Carrollton, Texas 75007
Phone: (972) 492-6474
Fax: (972) 492-4946

POLICY NUMBER: _____

PART I - POLICYHOLDER'S REPORT

1. NAME OF POLICY HOLDER	2. ADDRESS OF POLICY HOLDER Street City State Zip		
3. NAME OF INSURED PERSON	4. SOCIAL SECURITY NUMBER - -	5. SEX __F __M	6. BIRTHDAY ___ / ___ / ___
7. ADDRESS OF INSURED PERSON Street City State Zip			
8. PARENTS' NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE)			
9. DATE OF ACCIDENT	10. TIME OF ACCIDENT	11. PLACE WHERE ACCIDENT OCCURRED	
12. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)			
13. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT			

14. DID ACCIDENT OCCUR (CIRCLE YES OR NO) FOR EACH OF THE FOLLOWING:

A.	During a policyholder sponsored & supervised activity?	YES	NO
B.	During programmed hours?	YES	NO
C.	On activity premises?	YES	NO
D.	While on the job (if applicable)?	YES	NO
E.	While traveling directly and uninterruptedly to or from home and policyholder premises?	YES	NO
F.	During intercollegiate/scholastic athletic practice? YES NO or competition?	YES	NO

15. NAME OF EVENT OR ACTIVITY:	16. NAME & TITLE OF SUPERVISOR	
17. SIGNATURE OF POLICYHOLDER REPRESENTATIVE	18. TITLE	19. DATE

PART II - OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? YES NO
If Yes, name of insurance company _____ Policy #_____
Is the Claimant enrolled as an individual, employee or dependent member of one of the following?
1. Any accident/health/sickness or other type of health insurance? YES NO
If Yes, name of insurance company _____ Policy #_____
2. Preferred Provider Organization (PPO) or similar prepaid health care plan? YES NO
If Yes, name of insurance company _____ Policy #_____
3. Health Maintenance Organization (HMO) or similar prepaid health care plan? YES NO
If Yes, name of insurance company _____ Policy #_____
4. Any other type of accident/health/sickness plan? YES NO
If Yes, name of organization: _____ Policy #_____
If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
Name of Insurance Company _____ Policy #_____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
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	WITNESS	DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **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 _____ **DATE** _____

FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

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.

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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

DISTRICT OF COLUMBIA RESIDENTS: 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: Any 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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

NEW HAMPSHIRE: 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 JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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 YORK: 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 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.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA: Any person who, with the 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 may have violated state law.