METROPOLITAN D.C.-VIRGINIA SOCCER ASSOCIATION
ACCIDENT MEDICAL CLAIM FORM

GUIDELINES FOR SUBMITTING A SOCCER ACCIDENT CLAIM FORM

1. Complete **ALL** questions on the Soccer Accident Claim Form.
2. Have the authorized official with your local organization sign **Section II** (LOCAL OFFICIAL VERIFICATION).
3. Sign the claim form in **Section V** (STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION.)
4. File this claim form within 30 days of the date of accident or as soon thereafter as is reasonably possible.
5. If you have primary insurance, you must submit all charges to your primary carrier first. You will receive a Explanation of Benefit worksheet (EOB) from your other carrier. The EOBs may be attached to this claim form. Do not wait until your primary carrier has processed all your bills before filing a Soccer Accident Claim Form.
6. You may attach itemized bills and your other carrier's EOBs that are ready at the time of submitting this Claim Form.
7. Send the Claim Form to the Metropolitan D.C.-Virginia Soccer Association (MDCVSA) for verification and the authorized state signature. **DO NOT SEND THE CLAIM FORM DIRECTLY TO THE INSURER AS THIS WILL CAUSE A DELAY IN THE PROCESSING OF YOUR CLAIM**
8. Upon receipt of the claim form from MDCVSA, the claims administrator, K&K Insurance Group will forward an acknowledgement letter confirming receipt of your claim. All future correspondence concerning your claim should be directed to them at the address and phone number listed on your acknowledgement letter.

HELPFUL REMINDERS

1. A $500 deductible and 70/30 co-insurance provision applies per covered accident for the 1/1/23 - 1/1/24 policy year. If the MDCVSA accident policy is primary (no other insurance available to injured claimant) the deductible increases to $2,500 with 70/30 co-insurance. Eligible charges will be paid per the policy terms.
2. Each itemized bill MUST show the following:
   - Provider of Service's Name
   - Provider's Address
   - Provider's Federal Tax ID#
   - Provider's Telephone #
   - Date of Service
   - Diagnosis Description or Codes (ICD-10)
   - Procedure Description or Codes (CPT)
   - Charge for each Procedure
3. Additional bills can be submitted at a later date (after the initial submission of your claim) and should be mailed directly to K&K Insurance Group, Inc. PO Box 2338, Fort Wayne, IN 46804 and include the following: Name of the claimant, policy number (9Z-AID-34502234-01), claim number, and that you are a member of the Metropolitan D.C.-Virginia Soccer Association.
4. Please allow time to properly process your claim.
5. Please respond promptly to any correspondence requesting additional information. It is the Claimant's responsibility to request this information from the provider of service or from your primary insurance carrier.

MOST FREQUENTLY ASKED QUESTIONS

What is an itemized bill?
An itemized bill is a detail of the procedures performed by a licensed provider of service; i.e. Hospital, Clinic, Physician, etc.

What if I don't have an itemized bill?
The Claimant must request this information from the provider of service. Some providers only mail a balance due statement. The insurer is unable to process any charges without an itemized bill. Again, request this information from the provider service. Explain that you have excess / secondary accident medical coverage.

Can you process this claim with my other insurance carrier's worksheet alone?
No, the Payment Explanation (EOB) from your other insurance does not have complete information to process this claim.

What if I don't have my other carrier's payment explanation (EOB)?
The Claimant must request the EOB from their other insurance carrier.

IMPORTANT
This claim form must be mailed to your state association listed below:

MDCVSA
Attn: MaryBeth Falk
1357 Caroyln Drive
Virginia Beach, VA 23451

POLICYHOLDER: THE METROPOLITAN D.C.-VIRGINIA SOCCER ASSOCIATION

POLICY NUMBER: 9Z-AID-34502234-01

POLICY YEAR: 1/1/24-1/1/25

SECTION I TO BE COMPLETED BY CLAIMANT (PARENT OR GUARDIAN IF UNDER AGE 18)

1. Name: (LAST)_____(FIRST)_____(MIDDLE) _____
2. Date of birth: _____ / _____ / _____ 3. Sex: ☐ Male ☐ Female
4. Home Address: (STREET)_____
   (CITY) _____ (STATE) _____ (ZIP CODE) _____
5. Type of claimant: ☐ Player ☐ Coach/Asst Coach ☐ Other: _____
6. Accident date: _____ / _____ / _____
7. Description of injury (Indicate LEFT or RIGHT; i.e. Left Leg): _____
   _____
8. Did accident occur during (✓ all that apply) ☐ game ☐ practice ☐ tournament ☐ indoor soccer
   ☐ sanctioned/sponsored activities ☐ travel directly and interruptedly to or from activity premises
9. Describe how injury was sustained:_____
   _____
10. Name of field / facility where accident occurred: _____
11. Name of local league or club: _____
12. Name of team:_____
13. Name of witness (Coach, Manager or Referee) present at time of injury: _____
14. Phone # of above witness: _____

SECTION II LOCAL OFFICIAL VERIFICATION

Signature of Local Official	Local Official Name (print) and Title	Date

SECTION III AUTHORIZED STATE OFFICIAL *

I, _____, of the Metropolitan D.C.-Virginia Soccer Association certify that the above claimant was a registered player, coach, assistant coach, or participant at the time the accident occurred.

*Signature of Authorized State Official	Title	Date

*** Must be signed by the authorized MDCVSA administrator with the state soccer office.**

CLAIMANT'S NAME: _____

FAILURE TO COMPLETE THIS FORM MAY RESULT IN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

SECTION IV OTHER INSURANCE

Is claimant covered under ANY other insurance policy? ☐ Yes ☐ No

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____

Insured Name: _____

Insured ID #: _____ Insured Group # / Name: _____

SECTION V STATEMENT OF CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION

The following fraud language is made part of and cannot be removed from this claim form. Please read thoroughly.

District of Columbia: Any person who knowingly (or willfully) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully) presents false information in an application for insurance is

Virginia: 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.

I hereby certify that I have read the fraud statement and all information submitted on the claim form is true and complete.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Claimant Date

SECTION VI IMPORTANT NOTICE

This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with our itemized bill and this completed form.

ALL BENEFITS WILL BE MADE PAYABLE TO DOCTORS AND HOSPITALS INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

Coverage Underwritten by: Nationonal Union Fire
K&K Insurance Group
1-800-237-2917