



# NOTIFICATION OF INJURY

FOR OFFICE USE ONLY

**MAIL CLAIM FORM TO:**  
**MAKSIN MANAGEMENT CORP**  
 Kevon Office Center • Suite 160  
 2500 McClellan Avenue  
 Pennsauken, NJ 08109  
 (609) 486-7400 800-257-6250

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

Policy Number JOK 0685612
Reference Number
Coverage Code

## CLAIM INSTRUCTIONS

~~• PRIMARY EXCESS — The first \$100.00 of eligible covered expenses will be paid without regard to other valid and collectible insurance. Additional eligible covered expenses will be paid only when they are in excess of other valid and collectible insurance.~~

• FULL EXCESS — Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance. You must submit your claim to your other

insurance company first. When you receive their Benefit Statement (EOB), send it to us, along with corresponding itemized bills. Benefits for eligible expenses will be paid per policy terms.

• The claim form must be submitted within 90 days from the date of injury. Treatment must commence within 90 days from the date of injury.

• Note the name of the school district on all bills and

correspondence. NO ADDITIONAL CLAIM FORM IS NECESSARY.

• Do not rely on the provider to file your claim for you. You are responsible for filing your claim form and all additional information.

• All payments will be made to the providers of service (Hospital, Physician and others), unless accompanied by a paid receipt.

## PART I - SCHOOL REPORT

1. Name of School		2. School District Diocese of Fort Wayne-South Bend, Inc.					
3. Name of Student	Last	First	Middle Initial	4. Social Security No.	5. Grade	6. Birthdate	7. Sex
8. Nature of Injury (Please describe fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.)							
9. Describe how accident occurred. (Give all possible details.) <b>MUST BE A BODILY INJURY DUE TO ACCIDENT.</b>							
10. Did Accident Occur:		Yes	No	11. a) Date of Accident		12. Name of Activity	
a) While claimant was supervised		<input type="checkbox"/>	<input type="checkbox"/>	b) Time		13. Name and Title of Supervisor	
b) During sponsored activity		<input type="checkbox"/>	<input type="checkbox"/>	c) Place			
c) During programmed hours		<input type="checkbox"/>	<input type="checkbox"/>				
d) On activity premises		<input type="checkbox"/>	<input type="checkbox"/>				
e) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities.		<input type="checkbox"/>	<input type="checkbox"/>				
14. Signature of School Officer			15. Title		16. Date		

**NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL**

## PART II - TO BE COMPLETED BY CLAIMANT - OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian		2. Social Security No.	
3. Name of Mother or Guardian		4. Social Security No.	
5. Address of Parents or Guardian/or Claimant		5A. Telephone Number	
6A. Father or Guardian's Insurance Company(ies)	6B. Mother or Guardian's Insurance Company(ies)	Check One: <input type="checkbox"/> Individual <input type="checkbox"/> Group	
7A. Name and Address of Father or Guardian's Employer		7B. Name and Address of Mother or Guardian's Employer	
8. List other insurance policies under which claimant is insured		Policy No.	<input type="checkbox"/> Individual <input type="checkbox"/> Group
1. _____		1A. _____	
2. _____		2A. _____	<input type="checkbox"/> Individual <input type="checkbox"/> Group

**Affidavit:** I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent or Guardian

Date

**Authorization:** I hereby authorize any physician or hospital who has treated or attended the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian if Insured is under 18)

Date

**IF YOU HAVE AN ITEMIZED STATEMENT FROM THIS PROVIDER OF SERVICES,  
ATTACH THE STATEMENT(S) TO THIS FORM AND  
DISREGARD THIS SECTION  
TO BE COMPLETED BY ATTENDING PHYSICIAN**

*Please Print or Type*

1. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		2. DATE FIRST CONSULTED YOU FOR THIS CONDITION		3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Was there any congenital, predisposing or preexisting condition relevant to this injury or illness? If yes, please explain.				4. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
5. NAME OF REFERRING PHYSICIAN				IF HOSPITALIZED - GIVE NAME AND ADDRESS OF FACILITY	
6. ARE THESE CHARGES BEING SUBMITTED FOR CONSIDERATION BY ANOTHER INSURANCE CARRIER?					
7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, etc. OR DX CODE					
1. _____					
2. _____					
8. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services or Circumstances)					
A. DATE OF SERVICE		B. PLACE OF SERVICE		C. PROCEDURE CODE (IDENTIFY)	
				D. DIAGNOSIS CODE	
				FEE	
				ADMINISTRATIVE USE ONLY	
9. SIGNATURE OF PHYSICIAN OR SUPPLIER			*PLACE OF SERVICE CODES 1-(H) -INPATIENT HOSPITAL 2-(OH) -OUTPATIENT HOSPITAL 3-(O) -DOCTOR'S OFFICE		
SIGNED _____ DATE _____			10. TOTAL CHARGE		
13. YOUR PATIENT'S ACCOUNT NO.			11. PROVIDER SOCIAL SECURITY NO.		
15. YOUR PATIENT'S NAME			12. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
16. YOUR PATIENT'S AGE			14. PROVIDER TAX I.D. NO.		

**MUST BE ANSWERED ON ALL DENTAL CLAIMS: Condition of Teeth prior to accident (Indicate whole, sound, natural filled, capped, or artificial)**

1. DENTIST NAME		6. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATE	
2. MAILING ADDRESS		7. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?					
3. CITY, STATE, ZIP		8. ARE ANY SERVICES COVERED BY ANOTHER PLAN?					
4. DENTIST SOC. SEC. OR T.I.N.*		DENTIST LICENSE NO.		DENTIST PHONE NO.		9. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
						(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT	
5. HAS TREATMENT BEEN COMPLETED?		YES	NO	IF NOT, WHAT MUST BE DONE AND WHEN?		10. IS TREATMENT FOR ORTHODONTICS?	
						IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

<p>INDICATE MISSING TEETH WITH AN 'X'</p>	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER ADA CODES	FEE	ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.			TOTAL FEE \$	
SIGNED (DENTIST) _____ DATE _____			Your Patient's Account No. -	
Must be furnished under Authority of Law when Benefits Assigned			Your Patient's Age -	