Preferred Plan
"The Network of Choice."

MultiPlan Call 800-557-6794 for Facilities Referral

HSR
Health Special Risk, Inc.

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO:
Health Special Risk, Inc.
HSR Plaza
4001 North Josey Lane
Carrollton, TX 75007
Phone: (888) 765-7223 Fax: (972) 492-4946
E-Mail: claims@hsri.com

Policy Number: MAR14861

School Name (if applicable):

PART I – POLICYHOLDER'S REPORT

1. NAME OF POLICY HOLDER	2. ADDRESS OF POLICY HOLDER			
DIOCESE OF GREAT FALLS	Street	City	State	Zip

3. NAME OF INSURED PERSON	4. SOCIAL SECURITY NUMBER	5. SEX	6. BIRTHDAY
	- -	☐F ☐M	___ / ___ / _____

7. ADDRESS OF INSURED PERSON
Street City State Zip

8. PARENTS' NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE)

9. DATE AND TIME OF ACCIDENT	10. PLACE WHERE ACCIDENT OCCURRED	11. WAS INSURED A PARTICIPANT, STAFF MEMBER, GUEST OR VOLUNTEER?

FOR DENTAL CLAIMS ONLY

12. INDICATE WHICH TEETH WERE INVOLVED IN THE ACCIDENT

13. DESCRIBE CONDITION OF INJURED TEETH PRIOR TO ACCIDENT:
☐ WHOLE, SOUND AND NATURAL ☐ FILLED ☐ CAPPED ☐ ARTIFICIAL

14. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.)

15. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT

16. DID ACCIDENT OCCUR (CHECK 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
G. During a USGF sanctioned event? (Gymnastics schools only)	☐YES	☐NO

17. NAME OF EVENT OR ACTIVITY:	18. NAME & TITLE OF SUPERVISOR	
19. SIGNATURE OF POLICYHOLDER REPRESENTATIVE	**20. TITLE**	**21. 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:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐YES ☐NO
If Yes, name of insurance company _____ 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 photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____