Camps & Clinics Claim Form

Institution: UW- _____

Type of Camp/Clinic _____

Send Claims to the following:

Debbie Monroe
Aon Risk Services Inc. of Wisconsin
10700 Research Dr, Suite 450
Milwaukee, WI 53226
Phone: 414-225-5368
Email: debra.monroe@aon.com

ACCIDENT CLAIM
(To Be Completed By the Injured Person)

FULL NAME (INJURED PERSON)			**SOCIAL SECURITY NUMBER**	
STREET ADDRESS			**TELEPHONE NUMBER (INCLUDE AREA CODE)**	
CITY OR TOWN, STATE, ZIP			**DATE OF BIRTH**	
PARENT'S NAME AND PHONE			**PARENT'S E-MAIL**	
POLICY HOLDER'S NAME Board of Regents of the University of Wisconsin System			**PHYSICIAN'S OR SURGEON'S NAME**	
STREET ADDRESS 780 Regent Street, Suite 145			**PHYSICIAN'S STREET ADDRESS, CITY, STATE, ZIP**	
CITY OR TOWN, STATE, ZIP Madison, WI 53715			**PHYSICIAN'S TELEPHONE NUMBER**	
POLICY NUMBER PTPN04986192			**IF HOSPITALIZED, NAME OF HOSPITAL**	
WHEN WERE YOU INJURED?	**DATE**	**TIME** **AM/PM**	**HOSPITAL STREET ADDRESS, CITY, STATE, ZIP**	
WHERE WERE YOU INJURED?			**IF APPLICABLE, NAME OF OTHER INSURANCE COMPANY**	
TYPE OF INJURY			**OTHER INSURANCE POLICY NUMBER**	**EMPLOYER NAME**
DESCRIBE FULLY HOW AND WHERE ACCIDENT OCCURRED (Attach Separate Sheet if Necessary)				

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier describe 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, prescriptions 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_____

Company: Ace American Insurance Co. by Aon Risk Services Inc., of Wisconsin

Updated 1/1/2014

(complete both sides of form)

PHYSICIAN'S REPORT

(To Be Completed By The Attending Physician)

Policy Holder's Name: Board of Regents of the University of Wisconsin System Policy No. PTPN04986192				
1. PATIENT'S NAME:				
2. NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)				
3. DESCRIBE ANY PRE-EXSISTING CONDITION OR OTHER DISEASE OR INFIRMITY WHICH MAY OR MAY NOT AFFECT PRESENT CONDITION.				
	OFFICE			
4. GIVE DATES OF TREATMENTS	HOME			
	HOSPITAL			
5. IS YOUR PATIENT DISABLED?	____YES ____NO	IF YES ____TOTAL ____PARTIAL DATE:	ABLE TO WORK ON: DATE:	RESUMED WORK ON: DATE:
6. FACTORS PRESENT PROLONGING DISABILITY				
7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?	____YES ____NO	CONTEMPLATE DISCHARGE DATE:	IF DISCHARGED, GIVE DATE:	
8. AMOUNT OF YOUR BILL FOR SERVICES TO DATE:				
PHYSICIAN'S SIGNATURE _____ DATE_____				
STREET ADDRESS_____				
CITY OR TOWN_____ STATE_____ ZIP_____				
TELEPHONE NUMBER (_____)_____-_____				

(complete both sides of form)