

# U.S. Specialty Insurance Company, Transportation Division

13403 Northwest Freeway, Houston TX 77040. Claim Department Phone 800.323.8121



## CLAIM FORM

<b>How to file a claim:</b>	<ol style="list-style-type: none"> <li>SECTION I and the AUTHORIZATION should be completed by the Claimant</li> <li>SECTION II should be completed by Motor Carrier or Employer</li> <li>Attending Physician's Statement must be completed on reverse side of this form</li> <li>Return completed form to U.S. Specialty Insurance Company (address above)</li> <li>Form should be typed or legibly hand printed</li> </ol>
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### SECTION I — TO BE COMPLETED BY OR FOR CLAIMANT

1. Claimant:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: MM/DD/YYYY	Social Security Number:
2. Street address:		City, State, Zip Code:		Telephone:
1. Your Occupation	Name of Motor Carrier you contract with or Employer:		Telephone:	Were you on Dispatch? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you married?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse's Name:		
3. Date of injury: MM/DD/YYYY	Describe how the accident occurred. Attach copy of Police Report if Motor Vehicle accident:		Time of Injury? Location of Injury?	
4. Date Reported MM/DD/YYYY				
5. Reported By:				
6. Cause of disability:	Date first disabled & unable to work:	Date of first treatment for this illness of injury:	Name & Address of Doctor:	
Can you work as of today? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date Doctor released you to return to work: Actual Return To Work Date:	Still treating or released? <input type="checkbox"/> Treating <input type="checkbox"/> Released		
7. Is this condition due to accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	What body parts are injured from this incident? Have you seen a doctor for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" what is the diagnosis?:		Is this condition due to an occupational injury or disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you an Employee and filing for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Do you have any other coverage?</b> a. Any other Group Health or Welfare Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever treated for the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No - if yes, When? - Include Name & Address of doctors:		If this is a late report (over 30-days), why is it being reported late?

### Authorization for Disclosure of Health Information

Claimant \_\_\_\_\_ Social Security# \_\_\_\_\_. I, \_\_\_\_\_, hereby authorize any healthcare provider, health insurer or pharmacy to disclose "protected health information", as defined by the Health Insurance Portability and Accountability Act "HIPAA" and applicable regulations (including information that can be used to identify me and that the an healthcare provider, health insurer or pharmacy created or received about my past, present or future health or condition, the provision of health care to me or the payment for this health care) as indicated below from my health care records for the purpose of assisting in my medical treatment or payment for that treatment:

Information to be disclosed:

- All Medical Records and Charts
- Prescription and Pharmacy Records
- Correspondence regarding medical care
- Managed Care Notes
- Payments or coverage under the plan
- Other (please specify)

**Unless checked below, the Plan will not disclose the protected health information regarding:**

- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- Psychiatric care
- Treatment for alcohol and/or drug abuse

Persons or Entities this information may be disclosed to are as follows:

- U.S. SPECIALTY INSURANCE COMPANY - Relationships to Claimant: **Insurer**
- Other persons or entities, Relationship to Claimant: \_\_\_\_\_

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date of signature.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

**SECTION II — TO BE COMPLETED BY EMPLOYER OR MOTOR CARRIER**

Policy & Certificate No.:		Insured's name:		Social Security No.:	Occupation:
Date enrolled:	Date hired:	Effective date of insurance:			At work full time and on Dispatch on the Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date last worked:	Date resumed work: Part Time: Full Time:		Is this an Employee claim for Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a Contractor claim Under the Group Accident/Occupational Injury Policy?: <input type="checkbox"/> Yes <input type="checkbox"/> No
What was the Return-To-Work Date, if applicable? Did the driver or, if employee, return to active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is insurance currently in force? <input type="checkbox"/> Yes <input type="checkbox"/> No	To what date is premium paid?
Status: <input type="checkbox"/> Temporary Lay Off <input type="checkbox"/> Other, Explain <input type="checkbox"/> Leave of Absence					
Name of Motor Carrier or if fleet driver or Texas employee, name of the Employer:				Telephone No.	
Address (Street, City, State, Zip Code):					
Date:		Signed:		Title:	

**SECTION III — PHYSICIAN OR PROVIDER INFORMATION**

Date of illness (first symptom) or injury (accident): What history did the patient provide for his treatment with you?		Date first consulted you for this condition:	Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date patient able to return to work:		Dates of total disability: From _____ Through _____	Dates of partial disability: From _____ Through _____
Name of referring physician(s):		For services related to hospitalization, give hospitalization dates: Admitted _____ Discharged _____	
Name of facility where services rendered (if other than home or office):		Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis or nature of illness or injury: 1. 2. 3. 4.			

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Send claims to:** U.S. Specialty Insurance Company  
13403 Northwest Freeway  
Houston, TX 77040

<b>Trust</b>	900	<b>Year:</b>		<b>Group</b>	
<b>Claim Type</b>		<b>Underlying Coverage</b>	<b>OccAcc</b> <input type="checkbox"/>	<b>WC</b> <input type="checkbox"/>	<b>CLEL</b> <input type="checkbox"/>
<b>Adjuster #</b>				<b>Claim Number</b>	

**Reserves:**

Medical	
Compensation/ Indemnity	
Other	
Rehab	
EL Compensation	
EL Expense	
Subrogation Potential	Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly <input type="checkbox"/>

Intake Comments and discussions relevant for claim:

Initial Handling Instructions:

Initials:

Date: