MultiPlan Call 800-557-6704 for Facilities Referral

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO >>>>>>>>>>>>>>>>
E-mail: claims@hsri.com

HSR

Health Special Risk, Inc.

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
Phone: (972) 512-5600 Fax: (972) 512-5820
1-877-534-PONY (7669)
(Toll Free Number)

Arranged by:

Underwritten by: Mutual of Omaha

PART I – PROFESSIONAL RODEO COWBOYS ASSOCIATION PROOF OF LOSS

This form must be completed and signed by the PRCA Member and PRCA Judge

Policy Number T5MP-P-052380

1. NAME OF INSURED PERSON	2. SOCIAL SECURITY NUMBER	3. SEX	4. BIRTHDAY
	- -	__F __M	__/__/__

5. ADDRESS OF INSURED PERSON — Street / City / State / Zip

6. PHONE ( )

7. ENTRY BASIS: PRCA CARD# _____ or PRCA PERMIT #: _____ or LOCAL ENTRY YES_____ NO_____

☐ PRCA RODEO ☐ PRO TOUR ☐ EXTREME BULLS

8. DATE OF ACCIDENT	9. DATE OF FIRST TREATMENT & NAME OF PHYSICIAN	10. PLACE WHERE ACCIDENT OCCURRED (Name of town, arena and event you were participating in when injury occurred)

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

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

13. IF HOSPITALIZED, NAME AND ADDRESS OF FACILITY WHERE TREATMENT OCCURRED	14. DATE(S) OF HOSPITALIZATION

PART II – OTHER INSURANCE STATEMENT

1. Do you have other medical insurance? YES_____ NO_____
If Yes, please furnish the following information:

Name of Policyholder (Athlete) / Policy Number / Social Security Number

Name of insurance carrier, address, and phone number.

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATIONS 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 PRCA MEMBER	WITNESS	DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on the attached statements.

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_____

PRCA JUDGE

I hereby verify that the above member participated in the _____ Rodeo or Activity on (date) _____ during which the injury allegedly occurred.

PRCA JUDGE'S SIGNATURE / TITLE / DATE

The PRCA Judge's signature is necessary to verify the Rodeo and the injury.