PO Box 979
Valley Forge, PA 19482
Phone: 610-933-0800
Fax: 610-935-2860
www.agadminstrators.com

Participant Accident Incident Report

Please complete and submit to A-G Adminstrators along with itemized bills and any primary insurance explanation of benefits. For questions, please contact A-G Adminstrators.

GENERAL INFORMATION

NAME OF PARTICIPANT | INCIDENT DATE | INCIDENT TIME | REPORT DATE

NFHS
POLICYHOLDER

FEMALE ☐ MALE ☐ DATE OF BIRTH

POLICY # US541083 CLAIMANT'S SOCIAL SECURITY # _____ E-MAIL ADDRESS _____

PARENTS' NAME/GUARDIANS' (if minor) | ADDRESS | CITY | STATE | ZIP | PHONE

INCIDENT INFORMATION

INCIDENT LOCATION _____ INCIDENT CAUSE _____

BODY PART _____ INCIDENT TYPE _____

ACTIVITY _____ BRIEFLY DESCRIBE THE INCIDENT _____

TREATMENT INFORMATION

WHERE WAS TREATMENT GIVEN? (CHECK AND COMPLETE ALL THAT APPLY)

☐ HOSPITAL NAME _____ DATE _____

☐ DOCTOR'S OFFICE ADDRESS, BY _____ DATE _____

☐ AT ACCIDENT SITE: WHERE, BY **WHOM?** _____ DATE _____

☐ FATALITY DATE _____

EMERGENCY TRANSPORTATION USED? ☐ AMBULANCE ☐ HELICOPTER ☐ OTHER _____

NAME OF WITNESS _____ ADDRESS | CITY | STATE | ZIP | PHONE

INSURED REPRESENTATIVE

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
ROBERT HOLLOWAY	1201 CLINTON/RAYMOND RD.	CLINTON	MS	39060	601-924-6400

TITLE	ORGANIZATION	E-MAIL ADDRESS
ASST. DIR OF ATHLETICS	MHSAA	RHOLLOWAY@MSSHSAA.COM

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION TO RELEASE INFORMATION

AFFIDAVIT: I verify that the 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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

PARTICIPANT SIGNATURE (Parent or guardian, if participant is a minor) _____ Date _____

AUTHORIZED ORGANIZATION SIGNATURE _____ Title ASST. DIR. Date _____