HOW TO FILE A DAN CLAIM

1. Please complete all sections of the DAN Claim Form. If a section does not apply to you, indicate this by writing N/A. If any sections of the form are incomplete this may delay processing or cause the claim to be returned to you for completion.

2. For treatment received in the USA, please advise your treatment providers to submit their claims using a Form UB04 (hospitals) or Form CMS 1500 (doctors and all other providers) to our office referencing your DAN Member ID # when filing, along with a copy of the benefit determination received from other medical or travel insurance you may have.

3. For treatment received outside the USA, please obtain and submit your itemized medical bills, medical reports that include a diagnosis, and a copy of the benefit determination from other medical or travel insurance you may have, as well as any payment receipts for your out-of-pocket expenses.

4. **Important Note About Other Medical Insurance**: For all US insureds except those who purchased their policy in the state of New York, DAN is Excess or Secondary coverage UNLESS your other insurance is a Medicare/Medicare Supplement, Tricare, or Medicaid plan. Therefore, if your only other coverage besides DAN is one of these plan types, please clearly note this on your claim form when filing and advise your treatment providers accordingly so they will know the order in which to file your claims to your insurance.

5. Make legible copies of all supporting bills, receipts, statements and any medical records that apply to your claim. It is important that you make copies of all of the documents you are submitting including your completed claim form. ***Your submitted forms/records will NOT be returned to you.***

Please forward all claims, forms and supporting documentation by mail, fax, or email to:

DAN CLAIMS
6 West Colony Place
Durham NC 27705
Phone: 1-919-493-0912
Fax: 1-919-493-3040
Email: claims@dan.org

Claim Form · ***Complete all blanks or the form will be returned***

1. MEMBER'S STATEMENT	Insured Member's Name (Last, First, MI) _____ Insured Member's Home Address Street_____ City_____State_____Zip_____ Daytime Phone ( ) _____	**Relationship to Insured** (Circle One) SELF SPOUSE CHILD **Insured's Birthdate** (Mo/Day/Year) _____
	Insured Member's Employer Name_____ Employer's Street Address_____ City_____State_____Zip_____ Employer's Phone ( ) _____ Non-DAN Insurance Co. Name_____ Non-DAN Insurance Co. Phone ( )_____	**DAN ID# DAN Dive Accident Plan #** _____ Group Policy # Standard, Master: G-201,223 Preferred Plan Group: G-202-513 Non-DAN Insurance Policy # _____ Attach copy of non-DAN ID card
	Spouse's Name (First, Last) _____ Spouse's Employer's Name_____ Employer's Street Address_____ City_____State_____Zip_____ Employer's Phone ( )_____ Spouse's Insurance Co. Name _____ Spouse's Insurance Co. Phone ( )_____	Spouse's Non-DAN Insurance Policy # _____ Attach copy of non-DAN ID card
	Where did the accident/injury occur? _____ Date of Accident _____ (Mo/Day/Year) In detail, describe the dive or snorkeling incident which caused the injury (Attach a separate piece of paper if necessary) _____ _____ _____	Is this claim the result of an injury while acting as a dive instructor, divemaster, professional photographer or while doing scientific dives under the auspices of the AAUS? □ Yes □ No Is this claim the result of a work-related injury? □ Yes □ No Have you filed with Workers Compensation? □ Yes □ No
	When was a doctor first seen for this injury? Date_____Doctor_____	

1. *Continued* **NON-DIVING MEDICAL CLAIMS FOR ACCIDENTS OCCURRING OUT OF THE HOME COUNTRY**	Date accident occurred_____Where did the accident occur?_____ Describe the accident_____ _____ _____ Were you hospitalized? □ Yes □ No If yes, please complete the following, and attach copies of bills or hospital discharge reports to confirm dates hospitalized_____ _____ _____ NAME OF HOSPITAL ADDRESS Dates confined _____ to _____ Date of first consultation with physician:_____ Name, address, & phone number of your regular physician:_____ _____ Name, address, & phone number of physician from whom treatment was received:_____ _____
2. ADDITIONAL CARRIER INFORMATION	In addition to the group insurance listed on front of the form, are health insurance benefits available from: *Check YES or NO for ALL questions* Travel Insurance? □ Yes □ No School Insurance? □ Yes □ No Blue Cross/ Blue Shield? □ Yes □ No Medicare? □ Yes □ No HMO? □ Yes □ No Accident Insurance? □ Yes □ No Any other Medical or Dental Plan? □ Yes □ No Name and address of insurance companies and organizations that sponsor the coverage: _____ _____ Have you, or will you, submit a claim against any other party for damages as a result of the accident or injury described in this form? □ Yes □ No
3. AUTHOR-IZATION TO OBTAIN MEDICAL INFORMATION and ASSIGN BENEFITS	**PATIENT OR PARENT MUST SIGN BELOW** I hereby authorize any insurance company or prepayment organization, employer, hospital, or physician to release all information with respect to me or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. I also agree that a photostatic copy of this authorization shall be as valid as the original. Insured Member's Signature Patient's Signature (If Not Insured Member) Date _____ _____ _____
	IF PAYMENT IS TO BE MADE TO THE PROVIDER, SIGN BELOW I hereby authorize payment of benefits otherwise payable to me for services, to any provider of service, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization. Insured Member's Signature Patient's Signature (If Not Insured Member) Date _____ _____ _____
4. IMPORTANT	Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. This notice does not apply in Virginia. All statements contained in this form are true and complete to the best of my knowledge. Insured Member's Signature Patient's Signature (If Not Insured Member) Date _____ _____ _____

THIS CLAIM CANNOT BE PAID WITHOUT COPIES OF ALL OTHER CARRIERS' EXPLANATION OF BENEFITS (EOB) FORMS. PLEASE ATTACH OR SEND AS SOON AS POSSIBLE. YOUR CLAIM WILL BE PENDED UNTIL THESE EOBS ARE RECEIVED.