WFTDA MEDICAL CLAIM FILING INSTRUCTIONS

1. **Within 14 days of your injury**, fully complete the First Report of Accident and return to WFTDA: **Accident reports received after the allowable deadline will not be eligible for claims.** All First Reports of Accident must be approved by WFTDA for consideration of claims.

    - EMAIL (**PREFERRED**): CLAIMS@WFTDA.COM
    - FAX: 801-415-9648
    - MAIL: 1905 WEST 4700 SOUTH #212 SALT LAKE CITY, UT 84129

    WFTDA will verify coverage and submit a copy of the First Report of Accident to American Specialty Insurance & Risk Services, Inc.

2. American Specialty Insurance & Risk Services, Inc. will send a coverage letter to the injured person with a Proof of Loss form that needs to be completed, signed and returned to:

    American Specialty Insurance & Risk Services, Inc.
    7609 W. Jefferson Blvd.
    Claims Department, Suite 150
    Fort Wayne, IN 46804

3. The policy is excess over any other valid and collectible insurance therefore, all medical bills should be submitted to your primary medical insurer prior to submitting them to American Specialty. If there is a balance due after primary insruance consideration, please submit the itemized medical bill (**HCFA1500** from physician or **UB04** from hospital) **and** the corresponding **Explanation of Benfits** (EOB). **OR**

    Provide American Specialty as a secondary insurance with the medical providers for the injury reported. The medical provider will then submit any outstanding balance after primary insurance directly to American Specialty for consideration.

FIRST REPORT OF ACCIDENT

MUST BE SUBMITTED WITHIN 14 DAYS OF INJURY TO:
EMAIL (PREFERRED): CLAIMS@WFTDA.COM
FAX: 801-415-9648
MAIL: 1905 WEST 4700 SOUTH #212
SALT LAKE CITY, UT 84129

AMERICAN SPECIALTY®

DATE OF INCIDENT_____ **TIME OF INCIDENT**_____**AM/PM** Team/Club/Organization:_____ Address:_____ Telephone Number:_____	**DOES THE INJURED PERSON HAVE OTHER MEDICAL INSURANCE?** ☐Yes ☐No If so, please provide: Name of Company:_____ Policy #:_____
INJURED PERSON: ☐Athlete ☐Official ☐Coach ☐Spectator ☐Employee ☐Volunteer ☐Other _____ _____	**DID THIS TAKE PLACE DURING:** ☐Practice ☐Pre-Game ☐During Game ☐Post Game ☐While Traveling ☐Other _____

INJURED PERSON INFORMATION

Last Name First Middle		Telephone Number ( )	☐Single ☐Married
Address		Employer Name_____ Address_____	
City State Zip		_____	
Age	D.O.B. ☐Male ☐Female		

GUARDIAN/PARENT (IF INJURED PERSON IS A MINOR)

Last Name First Middle		Telephone Number ( )
Address	City	State Zip

INCIDENT LOCATION
- ☐Competition area
- ☐Parking lot
- ☐Restrooms/locker rooms
- ☐Premises/grounds
- ☐Bleachers/stands
- ☐Concession area
- ☐Admission area
- ☐Off property
- ☐Store area

INCIDENT
- ☐Assault/Sexual
- ☐Assault/Non-Sexual
- ☐Fall (different level)
- ☐Fall (same level)
- ☐Caught in, on, between
- ☐Collision (with object)
- ☐Collision (participant/participant)
- ☐Collision (participant/spectator)
- ☐Collision (spectator/spectator)
- ☐Struck by falling/flying object
- ☐Animal/insect bite/sting
- ☐Slip, bodily reaction
- ☐Slip/Fall
- ☐Aquatic
- ☐Overexertion

PRIMARY INJURY
- ☐Allergy
- ☐Amputation
- ☐Abrasion
- ☐Laceration
- ☐Drowning
- ☐Hypertension
- ☐Cold Injury
- ☐Seizures
- ☐Strain/Sprain
- ☐Sting/bite
- ☐Dislocation
- ☐Electrical Shock
- ☐Foreign Body
- ☐Fracture
- ☐Heat Exhaustion
- ☐Cardiac
- ☐Contusion
- ☐Concussion
- ☐Tooth/Mouth
- ☐Nausea
- ☐Stroke
- ☐Burn
- ☐Death
- ☐Pain
- ☐Illness

BODY PART INJURED
- ☐Eye (L/R)
- ☐Nose
- ☐Neck
- ☐Ear (L/R)
- ☐Knee (L/R)
- ☐Internal
- ☐Shoulder (L/R)
- ☐Elbow (L/R)
- ☐Wrist (L/R)
- ☐Torso
- ☐Back
- ☐Face
- ☐Leg (L/R)
- ☐Ankle (L/R)
- ☐Hip (L/R)
- ☐Foot (L/R)
- ☐Hand (L/R)
- ☐Finger or Toe
- ☐Arm (L/R)
- ☐Tooth
- ☐Head

DISPOSITION
- ☐Released to parent
- ☐Refusal of care
- ☐Refer to doctor
- ☐Refer to hospital or clinic
- ☐Medical attention
- ☐EMS transport
- ☐Patient requested EMS transport
- ☐Released to personal vehicle
- ☐Police
- ☐Ambulance
- ☐Report only

CLASSIFICATION
- ☐Non-injury
- ☐Minor injury or illness
- ☐Serious injury or illness

Describe how the incident occurred: ***(attach a separate sheet if necessary)***

WITNESS INFORMATION

NAME	ADDRESS	TELEPHONE NUMBER
1.		( )
2.		( )

SIGNATURE OF COACH (with no relationship to claimant)_____

PHONE #_____ **DATE**_____