HSR
Health Special Risk, Inc.

Providers
Send Claims and EOB's to:
HEALTH SPECIAL RISK, INC.
4100 Medical Parkway
Carrollton, Texas 75007
P: 972-512-5600 | F: 972-512-5820
csuclaims@hsri.com

Club Sport / Intramural / Recreational Sports Athletic Accident Claim Form

csurma
California State University Risk Management Authority

Please complete and submit to HSR with itemized medical bills and primary insurance explanation of benefits. For questions, please contact HSR.

College/University _____Fresno State_____

Club/Student Organization _____

Athlete's Name_____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth_____ Sex: ☐ Male ☐ Female Cell Phone _____

LAST FOUR DIGITS SOCIAL SECURITY # | | | | |

Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address_____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Sport _____ Accident Date_____

Circumstance: ☐ Game ☐ Practice ☐ Conditioning

Body Part Injured _____ Place of Accident_____

Nature of Injury — Details of What Happened _____

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

PROVIDER INSTRUCTIONS:

Health Special Risk, Inc. (HSR) is the plan administrator for the California State University Risk Management Authority (CSURMA). HSR is secondary to all other valid medical coverage held by the CSU student-athlete. All charges must be submitted to the student-athlete's primary insurance carrier for processing, prior to any excess payments made by HSR on behalf of the University and/or student-athlete. To make payment for an outstanding charge on a student-athlete's claim, HSR must receive the following three pieces of information to be considered a valid claim:

Required Documentation:
a. Completed and Signed Claim Form - Submitted from the University or student – athlete
b. HCFA/UB Forms - Submitted from the provider(s) or insurance carrier
c. Explanation of Benefits - Submitted from the insured or insurance carrier

AUTHORIZATION

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 HSR to the extent for which HSR 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 HSR 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.

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

_____ _____ _____
CLUB SPORTS ADMINISTRATOR Title Date