INJURY/ACCIDENT REPORTING PROCEDURE
PLAYERS AND COACHES
LAGUNA NIGUEL REGION 41

Note: Coach/Asst. Coach must have the Player Registration forms at all scheduled practices and games with "wet" signatures". It is suggested that the coach copy a set of these forms for the Asst. Coach, and have the parents re-sign these as well. Saddleback and Mission hospitals have verified that they will accept a copy of the Player Registration form, with an original parent's signature, in case the player needs treatment as a result of an injury/accident and the original Player Registration form is not available.

Coaches need to be safety conscious and take pro-active corrective measures as needed to include the cancellation of an activity if unsafe conditions cannot be corrected. In these instances, the coach should also notify their Division Commissioner, the Regional Commissioner and the Regional Safety Director.

1. In the case of injury or accident, the coach should limit their activity to basic first aid procedures. If additional medical attention is required, paramedics should be summoned by calling 911.

2. The coach should report the injury/accident within 24 hours to the Regional Safety Director at 949-363-8305 or by email to **safety@ayso41.org**. <u>The coach should also notify their Division Commissioner.</u>

3. In case of an injury/accident, the coach should complete the **INCIDENT REPORT** *and* **SOCCER ACCIDIENT INSURANCE (SAI) NOTIFICATION OF INJURY/CLAIM FORM <u>within 24 hours</u>** and send it to the Region 41 Safety Director as follows:

Safety Director and/or Regional Commissioner
AYSO Region 41
PMB 268
P.O. Box 30021
Laguna Niguel, CA 92607

4. Upon receipt of the **INCIDENT REPORT** and **SAI NOTIFICATION OF INJURY/CLAIM FORM**, the Regional Safety Director will provide the family with the appropriate information to initiate a Soccer Accident Insurance (SAI) claim. The Regional Safety Director will assist in verifying the player eligibility for coverage. It is the responsibility of the family (in the case of a player who has not reached majority age) or of the adult involved to follow the procedures of the carrier providing SAI coverage. A **PARTICIPATION RELEASE** form will also be provided.

5. In order for the injured party to be eligible to return to practice(s)/game(s), the player's parent or injured adult as well as their physician **<u>must</u>** complete the **PARTICIPATION RELEASE** form (if the injury/accident required medical attention) and return it to the Regional Safety Director as indicated above. Upon receipt and acceptance by the Regional Safety Director, the appropriate Division Commissioner will be notified.

Copies of the **INCIDENT REPORT** and **SAI NOTIFICATION OF INJURY CLAIM FORM** and the **PARTICIPATION RELEASE** form are attached. Please use as needed and contact me if additional forms are required.

NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for accident medical claims.

Policies With Excess Coverage

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other insurance or medical payment plan they must first submit claim to the primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Deductible ($200.00)

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

Claim Form

This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills, only one claim form is needed per accident/injury.

Medical Bills

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist

Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary? ______

If claim has first been submitted to the primary, are copies of EOB's (explanation of benefits) attached? ______

Is part (A) of the claim form completed by the Policyholder official or staff member and signed? ______

Is part (B) of the claim form completed by the injured person and signed? ______

Are the attached medical bills itemized in either a HCFA 1500 or UB92 form? ______

Is part (B), item number 3 (social security number) completed? ______

Mailing The Claim
When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

Dianna Taormina
American National Life Insurance Company of Texas
AYSO Accident Claims
The Loomis Company
P.O. Box 13906
Reading, PA 19612

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (888) 585-7065 or (800) 782-0392.

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement.

ACCIDENT DEDUCTIBLE CREDIT SHEET

INJURED'S NAME ______________________________

POLICYHOLDER'S NAME ______________________________

DATE OF INURY ______________________________

NAME & ADDRESS CHECK SHOULD BE SENT TO:

____

____

____

PROVIDER	DATE OF SERVICE	$ AMOUNT APPLIED TO DEDUCTIBLE
		$
		$
		$
		$
		$
		$

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

NOTICE

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties. California Residents: For your protection California law requires the following to appear on this form: "Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

PART A — This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.

1. Name of Organization (Policyholder)
American Youth Soccer Organization

2. Policy No.
FLD03-56378-BC

3. AYSO Region No.

4. Name of Organization or Team (if different from Policyholder)

5. Address of Organization (Street) (City) (State) (Zip)

6. Name of Injured Person (Insured) (First) (Middle) (Last)

7. AYSO ID

8. Date of Accident/Injury	9. Injury Occurred:	10. Type of Sport or Activity:
Mo. Day Year / /	Practice ❑ Travel ❑ Game ❑ Other_______________	

11. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.

12. Describe the nature of injury.

13. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ❑ No ❑	14. Name of Supervisor of Activity	15. Was he/she a witness to Yes ❑ No ❑

16. AYSO Regional Commissioner Signature	17. Date Signed	18. AYSO Safety Director Signature	19. Date Signed
X_______________		X_______________	

PART B — This PART **MUST** be **completed, dated** and **signed** by the Injured Person — or if the Injured Person is under age 18 or otherwise dependent — by his/her Parent or Guardian.

PRINT HERE — NAME OF PERSON COMPLETING FORM

Check one: Injured Person ❏ Parent ❏ Guardian ❏

Give the following information about the Injured Person:

1. Date of Birth Mo. Day Year / /	2. Male ❏ Female ❏	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes ❏ No ❏
If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian

Social Security No.
/ /

Place of Employment

Address of Employer

Area Code/Employer Phone No.
( )

Name of Mother or Female Guardian

Social Security No.
/ /

Place of Employment

Address of Employer

Area Code/Employer Phone No.
( )

9. If the Injured Person is married, give the following information:

Name of Spouse

Social Security No.
/ /

Place of Employment

Address of Employer

Area Code/Employer Phone No.
( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to American National Life Insurance Company of Texas or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. i understand that i or my authorized representative will receive a copy of this authorization upon request.

X____________________________________ Signature (in writing) of Responsible Party

____________________________________ Print Name

Check one: ❏ Injured Person ❏ Parent ❏ Guardian

Date:____________

AYSO
INCIDENT REPORT FORM
Use in the event of
Injury, Incident or Property Damage

Give this form to your Regional Commissioner or Safety Director

INJURED PERSON INFORMATION/PROPERTY DAMAGE OWNER:

Last Name | First Name | MI | Telephone:

Social Security #:

Address: | AYSO ID #

City: | State: | Zip: | Age: | D.O.B.: | ☐ Male ☐ Female

Employer Name & Address:

Team Name: | Section: : | Area: | Region:

Does the injured person have other medical insurance? ☐ Yes ☐ No *If yes, please provide name of company and policy #:* ______

INJURED PERSON: ☐ Player ☐ Official ☐ Coach ☐ Spectator ☐ Volunteer ☐ Other: ______

GUARDIAN/PARENT (*if injured person is a minor*):

Last Name | First Name | MI | Telephone Number: ( )

Address: | City: | State: | Zip:

INCIDENT INFORMATION: | Date of Incident: | Time of Incident: AM /PM

BODY PART INJURED			If ankle injury, was ankle:	PRIMARY INJURY	
? Ankle (L/R)	? Shoulder (L/R)	? Back	? Taped/Supported	? Abrasion	? Fracture
? Knee (L/R)	? Wrist (L/R)	? Neck	? Unsupported	? Burn	? Heat Exhaustion
? Nose	? Finger	? Internal	Shoes: ? Yes ? No	? Cardiac	? Nausea
? Head	? Eye (L/R)	? No injury	***If knee injury, was knee:***	? Cold Injury	? Laceration
? Tooth	? Ear (L/R)	? Other	? Braced/Supported	? Concussion	? Pain
			? Unsupported	? Contusion	? Seizures
			Knee Pads: ? Yes ? No	? Dislocation	? Sting/Bite
				? Foreign Body	? Strain/Sprain

LOCATION	INCIDENT		DISPOSITION	
? Before Competition/Event	? Collision (participant/spectator)	? Animal/insect bite/sting	*No care given:*	? Not Needed
? During Competition/Event	? Collision (with object)	? Slip/Fall		? Patient Refused
? After Competition/Event	? Collision (participant/participant)	? Overexertion	*Released:*	? To Parent
? Competition Area	? Collision (spectator/spectator)	? Assault/Sexual		? To Personal Vehicle
? Concession Area	? Struck by falling /flying object	? Assault/Non-Sexual	*Referral*	? To Doctor
? Parking Lot	? Caught in, on, between goal	? Property Damage		? To Hospital/Clinic
? Restrooms			*EMS transport::*	? Region Recommended
? Off Property				? Patient/Parent Requested
? Bleachers/Stands				

FIELD SURFACE ? Dirt ? Grass ? Indoor | **CLASSIFICATION** ? Non-Injury ? Minor Injury or Illness ? Serious Injury or Illness

POLICE REPORT FILED: ? Yes ? No ***If yes, report number:*** ***Officer's Name:***

Describe how the incident, injury or property damage occurred: (*use the backside or attach a separate sheet if necessary*)

WITNESS INFORMATION

Name	Address	Telephone Number

Person completing this form:

Name:	Signature:	Title:	Date:	Phone: ( )