ACCIDENT
CLAIM FORM

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Please review your policy for specific benefits covered under your plan.
To prevent processing delays, please have claim form completed in full and return the signed HIPPA.

Please submit medical documentation from your healthcare provider to support your claim. This information will be used to determine the benefit amount paid.

Email completed forms to claims@breckpoint.com

ACCIDENT CLAIM FORM			
Employer's Name:	Insured's Email:		
Insured's Medical Insurance Provider:	Insured Medical ID #:		
Insured's Name:	Social Security Number:	Date of Birth:	Gender:
Insured's Address: ☐ Check box if this is a permanent address change			
Patient's Name (person who is sick or injured):	Date of Birth:	Gender:	Insured's Phone #:
Relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent ☐ Other			
**By providing your email address above, you consent to the use of electronic transactions in connection with your Breckpoint policies, contracts, and/or account to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that Breckpoint may be legally required to deliver to you). Additionally, by providing your email address you consent to being contacted or processing transactions by automated machines regarding your Breckpoint policies.*			
Date of Injury:	Describe how the injury occurred:		
Was this injury caused by an incident that occurred while performing the duties for payment or profit? ☐ YES ☐ NO			
Has a Worker's Compensation claim been filed? ☐ YES ☐ NO If yes, status of the claim: ☐ Approved ☐ Pending ☐ Denied			
Was the patient injured in a motor vehicle accident? ☐ YES ☐ NO (If yes, please submit the Police Report.)			
Was the patient confined to the hospital as a result of this injury? ☐ YES ☐ NO (If yes, please include itemized bill or Explanation of Benefits)			
Admission Date:	Discharge Date:		
Hospital Name:	Hospital Address:	Tax ID Number:	

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Was the patient transported by an ambulance as a result of this injury? (If yes, please submit the Ambulance Bill.)	☐ YES	☐ NO
Was dental treatment for injured teeth provided as a result of this injury? (If yes, please submit a copy of the Doctor's notes and itemized bill.)	☐ YES	☐ NO
Was an aid in locomotion (mobility) prescribed as a result of this injury? (ie: Crutches, Wheel-chairs, Leg Braces, Walking Boots, Back Braces, Walkers, Cervical Collars) (If yes, please submit documentation from prescribing provider and the bill of sale reflecting the charges)	☐ YES	☐ NO
Were any prescriptions prescribed as a result of this injury? (If yes, please submit receipts with dates and charges.)	☐ YES	☐ NO
Were there any surgical procedures performed as a result of this injury? (If yes, please submit a copy of the operative report and itemized bill.)	☐ YES	☐ NO
Were there any anesthesia services performed as a result of this surgery? (If yes, please submit a copy of chart notes and itemized bill.)	☐ YES	☐ NO
Was a major diagnostic exam (ie: CT Scan, MRI, MRA, EEG) performed as a result of this condition? (If yes, please submit a copy of the exam report and itemized bill.)	☐ YES	☐ NO
Was there dislocation or broken bone as a result of this injury? (If yes, please submit x-ray and/or imaging reports and itemized bill.)	☐ YES	☐ NO
Provide all dates of treatment related to injury on the lines below. (Please submit supporting medical documentation for each visit indicated below.)		
Initial Date of Treatment:		
Initial Place of Treatment: ☐ Primary Care ☐ Urgent Care ☐ Emergency Room		
Follow up Visits:		
Name of Provider/Facility:	Tax ID:	
Address:		
Physical, Occupational, or Speech Therapy:		

Please see policy for time limit provisions.

5130 South Fort Apache #215-365, Las Vegas, NV 89148 ◂ (844) 798-4878 ◂ claims@breckpoint.com
To review claims status and verify eligibility please visit your Claims Member Portal. portal.breckpoint.com

HIPPA AUTHORIZATION
TO OBTAIN INFORMATION

breckpoint®
LEAD TOGETHER

Send to:

Breckpoint Inc.
5130 South Fort Apache
#215-365
Las Vegas, NV 89148

Phone: (844) 789-4878
Email: claims@breckpoint.com

Primary Certificate Holder:	SSN (Optional):	Date of Birth:	
Certificate Number(s):			
Address:	City:	State:	Zip code:
Name of Individual Subject to Disclosure (If not the Primary Certificate Holder):		Date of Birth:	
Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild			

I. Authorization:
For the purpose of evaluating my eligibility for insurance and for benefits under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information (defined below) about me and, if applicable, my dependents, from the sources listed below to Breckpoint, or any person or entity acting on its part.

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including Breckpoint or additional coverages) or healthcare clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Breckpoint will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that Breckpoint has taken action in reliance on this authorization. If I revoke this authorization, Breckpoint may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to Breckpoint at the address or above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that Breckpoint is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
• If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form
• If records are on a minor child the natural parent or legal guardian must sign on their behalf.

_____ _____
Signature of Individual Subject to Disclosure | Date Signed:

_____ _____ _____ _____
Legal Representative's Printed Name | Legal Representative's Signature | Legal Relationship | Date

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)