



SECTION 1: INSURED INFORMATION

Name of Insured	Policy Number	Home Phone	Cell phone
Street Address	City	State	Zip Code

SECTION 2: OTHER INSURANCE INFORMATION

Do you have any other insurance? ☐ Yes ☐ No If yes, Please complete the following:

Name of Insurance Company	Policyholder Name / Relation	Policy No.	Insurance Co. Phone #
Supplemental Insurance Company	Policyholder Name / Relation	Policy No.	Insurance Co. Phone #

Has a claim been filed with your Insurance Company? ☐ Yes ☐ No If yes, please provide a copy of the company's corresponding Explanation of Benefits for any bills you are requesting benefits for. If no, please submit the bill to your Insurance Company and provide us with a copy of the company's corresponding Explanation of Benefits

SECTION 3: DETAILS OF SICKNESS / INJURY

Date Sickness or Injury began: _____ Date of first treatment: _____

Nature of sickness / details of accident: _____

Have you ever been treated for this condition previously? ☐ Yes ☐ No . Date(s) of treatment(s): _____

Name, address and phone number of treating physician(s):

(1) Physician's Name: _____ Phone: _____

Address: _____

(2) Physician's Name: _____ Phone: _____

Address: _____



CRUM & FORSTER®
A FAIRFAX COMPANY

**MEDICAL EXPENSE
CLAIM FORM**

NEW YORK FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION: I hereby authorize Crum & Forster, United States Fire Insurance Company or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster, United States Fire Insurance Company or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. **I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.**

SIGNATURE OF INSURED _____ **DATE** _____

PLEASE COMPLETE THIS FORM IN FULL AND RETURN TO:

Online Portal: portal.bbadmin.com

Email: Claims@bbadmin.com

Fax: 512-275-9350

Mail: P.O. Box 161690 Austin, TX 78716

Questions?

Claims@bbadmin.com

1-855-900-4777, 8:30 a.m. – 5:00 p.m. EST