

# Member Access



A THIRD PARTY CLAIMS ADMINISTRATOR  
**FOCUSED SOLELY ON SERVICE**

- ACI's website: [www.visit-aci.com](http://www.visit-aci.com)
- Click "MEMBER RESOURCES"
- Click "CLAIM STATUS" -> "INSURED LOGIN" -> Below is the screen that will appear.
- Enter the required information under New Web User to establish a Username and Password.
- Once you have created an account, enter your Username and Password under the Return Visitor section.



| Returning Visitor   | New Web User  |
|---|---|
| Username<br><input type="text"/><br>Password<br><input type="password"/>  | Enter Member ID Number and Policy Number<br>as shown on your Insurance ID Card.<br>Member ID Number<br><input type="text"/><br>Policy Number<br><input type="text"/><br>Date of Birth<br><input type="text" value="MM/DD/YYYY"/><br>Choose a Username<br><input type="text"/><br>Choose a Password<br><input type="password"/><br>Confirm Password<br><input type="password"/><br>Your E-Mail Address<br><input type="text"/><br>Confirm Your E-Mail Address<br><input type="text"/><br>Question we can ask if you lose your password<br><input type="text"/><br>Answer to above Question (you should be the only one who knows the answer)<br><input type="text"/> |
| <input type="button" value="Log In"/><br><a href="#">Lost Your Password?</a><br><a href="#">Forgot Your Username?</a> | All fields are required.<br><input type="button" value="Register"/>   |



Agree to the Terms and Conditions of Access.  
Click Continue to Log in.



#### Terms & Conditions

##### TERMS AND CONDITIONS OF ACCESS

Administrative Concepts, Inc. (ACI) provides you with access to its ClaimStatus subject to the following Terms and Conditions ("Terms and Conditions"). We may update the Terms and Conditions at any time and without notice. Unless stated otherwise, changes will be effective when they are posted on our web site at [www.visit-aci.com](http://www.visit-aci.com). By logging on to ClaimStatus, activating your password and creating a user identification, you agree to be bound by these Terms and Conditions.

I agree to these terms.  I do NOT agree to these terms.

Continue

To view claim status, click “CLAIMS” tab OR View Claims link

The screenshot shows the ACI Claim Status website interface. On the left is a vertical navigation menu with buttons for HOME, CLAIMS (highlighted with a red box), ID CARD REQUEST, CLAIM FORM, CHANGE ADDRESS, and WEBSITE SETTINGS. The top right of the page features the text "INSURED MEMBER". Below this, the member's name "Harry Houseman" and "Demo University" are displayed. A welcome message states: "Welcome to the ACI ClaimStatus website for Insured Members of our health plans. The follow is a list of the members covered under your Member ID Number." The main content area lists four family members:

- Tina Houseman** (Spouse): Date of Birth 10/1/1982, Covered Periods 8/15/2003-Current.
- Harry Houseman** (Insured): Date of Birth 10/1/1980, Covered Periods 8/15/2003-8/14/2009. A "View Claims" link is circled in red.
- John Houseman** (Child): Date of Birth 1/1/2004, Covered Periods 8/15/2003-2/28/2004. A "View Claims" link is present.
- Debbie Houseman** (Child): Date of Birth 2/2/2001, Covered Periods 8/15/2003-9/14/2003. A "View Claims" link is present.

\* Due to HIPAA regulations we require separate logins and Member ID numbers for any dependent spouse or child who is 18 years or older to view claims.

- Click on the Claim Number to view the EOB for status.



## INSURED MEMBER

HOME

CLAIMS

ID CARD REQUEST

CLAIM FORM

CHANGE ADDRESS

WEBSITE SETTINGS

Match the dates of service and the total charge on the screen to your bill to determine the claim number to view.

Claims for: Harry Houseman

*Click a claim number to view details.*

| Claim Number             | Dates of Service        | Provider(s)                                       | Total Charge |
|--------------------------|-------------------------|---|--------------|
| <a href="#">219454-1</a> | 09/20/2003 - 09/22/2003 | ALLEN LAB INC, EDWARD MARTIN MD, EXPERT RADIOLOGY | \$663.85     |
| <a href="#">219471-1</a> | 11/02/2003              | EDWARD MARTIN MD                                  | \$147.00     |
| <a href="#">219471-2</a> | 11/03/2003              | ALLEN LAB INC                                     | \$48.00      |
| <a href="#">962829-1</a> | 03/10/2008              | WYLIE C HEMBREE MD                                | \$2,500.00   |
| <a href="#">962829-2</a> | 03/11/2008              | RAYLAND K BEURLLOT MD                             | \$300.00     |
| <a href="#">962824-1</a> | 07/01/2008 - 07/05/2008 | MICHAEL K LIPSCOMB MD                             | \$275.00     |
| <a href="#">962824-4</a> | 08/01/2008              | MUHAMMED IQBAL MD                                 | \$450.00     |
| <a href="#">962824-3</a> | 07/06/2008              | JACKSON HOSPITAL                                  | \$4,200.00   |
| <a href="#">962824-2</a> | 07/05/2008              | RIVER ACRES MEDICAL GROUP P                       | \$1,500.00   |
| <a href="#">355439-1</a> | 04/01/2005              | RAD ASSOC OF NEW MILFORD                          | \$2,500.00   |
| <a href="#">355439-2</a> | 04/01/2005              | RONALD D SMITH MD, PA                             | \$5,500.00   |
| <a href="#">300744-1</a> | 02/01/2005              | COMMUNITY HOSPITAL                                | \$840.00     |
| <a href="#">300747-1</a> | 05/05/2005              | EDWARD MARTIN MD, EXPERT RADIOLOGY                | \$202.00     |
| <a href="#">300747-2</a> | 06/01/2005              | COMMUNITY HOSPITAL                                | \$600.00     |

- Claim Status is noted in the upper right corner of the page.
- Pended claims include Reason Codes describing the additional information needed to process the claim.



## INSURED MEMBER

HOME

CLAIMS

ID CARD REQUEST

CLAIM FORM

CHANGE ADDRESS

WEBSITE SETTINGS

Claim 219454 - 1

Date: 2/1/2004 Claim Status: Processed

| Provider         | Dates of Service | Service | Total Charge    | Ineligible Amt | Amt Paid by Other Insurance | Reason | Discount Amt   | Covered By Plan | Deductible Amt  | Co-Pay Amt    | Balance         | Paid At | Payment Amt     |
|------------------|------------------|---------|-----------------|----------------|-----------------------------|--------|----------------|-----------------|-----------------|---------------|-----------------|---------|-----------------|
| EDWARD MARTIN MD | 09/20/2003       | 16      | \$92.50         | \$16.36        | \$0.00                      | 35     | \$0.00         | \$76.14         | \$76.14         | \$0.00        | \$0.00          |         | \$0.00          |
| ALLEN LAB INC    | 09/20/2003       | 08      | \$262.50        | \$0.00         | \$0.00                      | IM     | \$0.00         | \$262.50        | \$50.00         | \$0.00        | \$212.50        | 100%    | \$212.50        |
| ALLEN LAB INC    | 09/20/2003       | DS      | \$74.85         | \$0.00         | \$0.00                      | 96     | \$74.85        | \$0.00          | \$0.00          | \$0.00        | \$0.00          |         | \$0.00          |
| EXPERT RADIOLOGY | 09/22/2003       | 09      | \$234.00        | \$0.00         | \$0.00                      |        | \$0.00         | \$234.00        | \$23.86         | \$0.00        | \$210.14        | 70%     | \$147.10        |
| <b>Totals</b>    |                  |         | <b>\$663.85</b> | <b>\$16.36</b> | <b>\$0.00</b>               |        | <b>\$74.85</b> | <b>\$572.64</b> | <b>\$150.00</b> | <b>\$0.00</b> | <b>\$422.64</b> |         | <b>\$359.60</b> |

|                        |                  |
|------------------------|------------------|
| Paid To                | ALLEN LAB INC    |
| Paid Date              | 02/01/2004       |
| Check Number           | 00000003         |
| Check Amount           | \$212.50         |
| Paid To                | EXPERT RADIOLOGY |
| Paid Date              | 02/01/2004       |
| Check Number           | 00000004         |
| Check Amount           | \$147.10         |
| Patient Responsibility | \$229.40         |

### Service Codes

|    |                   |
|----|-------------------|
| 16 | PHYS OFFICE VISIT |
| 08 | DIAGNOSTIC LAB    |
| DS | PPO DISCOUNT      |
| 09 | DIAGNOSTIC XRAY   |

### Reason Codes

|    |   |
|----|---|
| 35 | CHARGES ARE OVER USUAL & CUSTOMARY  |
| IM | THIS CHARGE HAS BEEN DISCOUNTED BY THE IN-NETWORK PROVIDER. THE INSURED IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE DISCOUNTED AMOUNT AND THE AMOUNT PAID. DISCOUNTED BY MULTIPLAN. |
| 96 | MULTIPLAN DISCOUNT. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.  |

Print this Claim

In addition to claims status, Members the ability to:

- Request ID Card copy if applicable to the account
- Download a Claim Form
- Change Address
- Update an email address or change Password

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- John Houseman** (Child): Date of Birth 1/1/2004, Covered Periods 8/15/2003-2/28/2004. Includes a 'View Claims' link.
- Debbie Houseman** (Child): Date of Birth 2/2/2001, Covered Periods 8/15/2003-9/14/2003. Includes a 'View Claims' link.

\* Due to HIPAA regulations we require separate logins and Member ID numbers for any dependent spouse or child who is 18 years or older to view claims.

- Click "Claim Form" button
- Click "New Form" link to start



# INSURED MEMBER

## CLAIM STATUS

- HOME
- CLAIMS
- ID CARD REQUEST
- CLAIM FORM**
- CHANGE ADDRESS
- WEBSITE SETTINGS

Claim Forms for: John Houseman *Click a form number to complete the form.*

| Form Number              | Status     | Information |
|--------------------------|------------|-------------|
| <a href="#">New Form</a> |            |             |
| <a href="#">3001</a>     | Incomplete |             |

- Select Claim Type



## INSURED MEMBER

HOME

CLAIMS

ID CARD REQUEST

CLAIM FORM

CHANGE ADDRESS

WEBSITE SETTINGS

Select Claim Type

Accident  
 Sickness

Cancel

Continue

- Fully Complete claim details
- If information is not available at the time of submission, you may click “Finish Later” button



**CLAIM STATUS**

# INSURED MEMBER

- HOME
- CLAIMS
- ID CARD REQUEST
- CLAIM FORM
- CHANGE ADDRESS
- WEBSITE SETTINGS

### Accident Claim

1. Exact nature of injury

2. Date and hour of occurrence

3. Was the injury due to practice or play of a sport?  Yes  No  
a. Which sport?   
b.  Intercollegiate  Interscholastic  Intramural  Club  Other

4. Is condition work related?  Yes  No

5. Is condition due to an auto accident?  Yes  No  
If yes, please send in detailed policy information on all motor vehicles involved in accident.

6. Were you treated in the Health Service for this condition?  Yes  No  
a. Seen by  b. Date

7. If your claim is for services outside of the Health Service, were you referred?  Yes  No  
a. If not, why? Away from school   
b. For what reason

- Answer Other Insurance questions if applicable



**CLAIM STATUS**

## INSURED MEMBER

HOME

CLAIMS

ID CARD REQUEST

CLAIM FORM

CHANGE ADDRESS

WEBSITE SETTINGS

### Other Insurance

1. Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?

a. Mother's policy?  Yes  No

b. Father's policy?  Yes  No

c. Spouse's policy?  Yes  No

d. Other policy?  Yes  No

2. Have you filed a claim with any other insurance company?  Yes  No

Finish Later

Continue

- Certify the information given is true and correct
- Click Submit "Claim Form" button



# INSURED MEMBER

· Help · Log Off

- HOME
- CLAIMS
- ID CARD REQUEST
- CLAIM FORM**
- CHANGE ADDRESS
- WEBSITE SETTINGS

## Terms and Conditions

Administrative Concepts, Inc. does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

## Important Claim Notices

**California Residents:** Any person who knowingly presents a 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.

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Maine/Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Maryland/Oregon Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of a felony.

**Nevada Residents:** Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

**New Hampshire Residents:** Any person who, with the purpose to injure defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A.638.20.

**New York Residents:** 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 be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

**Oklahoma Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes a claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania Residents:** 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 subjects such person to criminal and civil penalties.

**Texas Residents:** Any person who knowingly presents a 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.

**Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I certify that the information given by me in support of my claim is true and correct  Yes  No

Finish Later Submit Claim Form

- Supporting claim documentation can be uploaded after the claim form is submitted or can be sent to ACI by mail, fax, or email.



## INSURED MEMBER

### CLAIM STATUS

[Help](#) [Log](#)

- HOME
- CLAIMS
- ID CARD REQUEST
- CLAIM FORM
- CHANGE ADDRESS
- WEBSITE SETTINGS

Thank You for Your Claim Form Submission. You must now submit your supporting claim documentation including itemized bills, receipts, and any other documentation via one of the methods listed below. Please indicate your policy number on all documentation. If you have any questions, please call 610-293-9229 and press 2 for Customer Service.

**By Mail** Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802

**By Fax** 610-293-9299, Attn: Claims Department

**Online** [Click Here to securely upload files to this Claim Form](#)

#### Accident Claim

1. Exact nature of injury:

(Not Answered)

2. Date and hour of occurrence:

3. Was the injury due to practice or play of a sport? (Not Answered)

a. Which sport? (Not Answered)

b. Type (Intercollegiate, Interscholastic, Intramural, Club, Other): (Not Answered)

4. Is condition work related? (Not Answered)

5. Is condition due to an auto accident? (Not Answered)

If yes, please send in detailed policy information on all motor vehicles involved in accident.

6. Were you treated in the Health Service for this condition? (Not Answered)

a. Seen by: (Not Answered) b. Date: (Not Answered)

7. If your claim is for services outside of the Health Service, were you referred? (Not Answered)

a. If not, why? Away from school: NO

b. For what reason

(Not Answered)

#### Other Insurance

1. Have you been covered (as an insured or dependent) by any other hospital and/or medical plan for the past 12 months?

a. Mother's policy? (Not Answered)

b. Father's policy? (Not Answered)

c. Spouse's policy? (Not Answered)

d. Other policy? (Not Answered)

2. Have you filed a claim with any other insurance company? (Not Answered)

[Click Here to securely upload files to this Claim Form](#)

Done