Helpful Hints

ACCIDENTAL INJURY / SICKNESS CLAIM FORM

Failure to complete the required sections may result in a delay in processing this claim.

We value you as a policyowner and want to make the process of filing a claim as fast and as simple as possible. To assist you with the process, we are providing these instructions:

HOW TO COMPLETE THE CLAIM FORM

ACCIDENTAL INJURY CLAIM

- ✓ **Section A: Policyowner/Patient Information** – Complete this section and be sure to sign.
- ✓ **Section B: Accidental Injury Physician's Statement** – Have your doctor complete this section or submit the Emergency Room Report.
- ✓ **Complete and return the enclosed HIPAA Privacy Authorization Form.**

SICKNESS CLAIM

- ✓ **Section A: Policyowner/Patient Information** – Complete this section and be sure to sign.
- ✓ **Section C: Sickness Claim Statement of Loss** – Complete this section.
- ✓ **Section D: Sickness Claim Physician's Statement** – Have your doctor complete this section.
- ✓ **Complete and return the enclosed HIPAA Privacy Authorization Form.**

SUPPORTING DOCUMENTATION

Failure to submit required documentation may result in a delay in processing this claim.

- ✓ Submit copies of all bills related to this claim such as ambulance bills, doctor visits, follow-up visits, and any other documentation related to this claim such as radiology reports (from x-rays taken), operative reports (from any surgeries), etc. All bills should be ***itemized*** and should include the diagnosis and diagnosis code, services rendered with corresponding CPT code for each service and actual charges for each service.
- ✓ If you were treated in the emergency room, send us a copy of the emergency room report.
- ✓ We require a copy of the police accident report and toxicology report (if applicable) for all injuries resulting from motor vehicle accidents and other incidents investigated by any law enforcement agency.
- ✓ Send a copy of your hospital bill that lists the number of days confined. All hospital confinements require an ***itemized*** bill and one of the following forms: UB 92, UB 04 or CMS 1450.
- ✓ If confined to an intensive care unit, please send a copy of your hospital bill that shows charges and the number of days spent in the intensive care unit. Your intensive care claim cannot be processed without the hospital bill.
- ✓ Please include a certified copy of the death certificate if the patient is deceased.
- ✓ Be sure to include your policy number(s) on all documents.

WHERE TO SUBMIT CLAIMS

Mail all Accidental Injury and Sickness Claims to:

Claim Processing
PO Box 2024
Carmel IN 46082-2024

Phone calls can be directed to (800) 541-2254.

THREE COMMON REASONS WHY CLAIMS ARE DELAYED

1. No supporting documentation (police reports, medical bills, death certificate, etc.) submitted with original claim form.
2. Policy numbers not included on claim form and/or supporting documentation.
3. Physician's Statement not submitted with original claim form or not properly completely.

ACCIDENTAL INJURY / SICKNESS CLAIM FORM

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Servicing is provided for the following companies:

- ☐ Conseco Insurance Company
- ☐ Conseco Health Insurance Company
- ☐ Conseco Senior Health Insurance Company
- ☐ Washington National Insurance Company

FILING CLAIM FOR: ☐ Accidental Injury ☐ Sickness ☐ Deceased – Date Deceased: _____/_____/_____

SECTION A: POLICYOWNER/PATIENT INFORMATION

POLICYOWNER INFORMATION

POLICY NUMBER		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE _____/_____/_____	PHONE NUMBER (HOME) ( )
ADDRESS	☐ Check box if this is a new permanent address	
CITY	STATE	ZIP
PLACE OF EMPLOYMENT	PHONE NUMBER (WORK) ( )	
ADDRESS		
CITY	STATE	ZIP

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	PHONE NUMBER ( )

FOR ACCIDENT CLAIMS: DID THIS ACCIDENT OCCUR AT ☐ HOME OR ☐ WORK?

☐MALE ☐FEMALE | ☐SINGLE ☐MARRIED ☐OTHER | RELATIONSHIP: ☐SELF ☐SPOUSE ☐DEPENDENT – CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐

Claimant Signature (or Authorized Representative) ______________________________ Date __________

Policyowner Signature ______________________________ Date __________

Claim Department, P O Box 2024, Carmel IN 46082-2024
Fax: (317) 208-8656

ACCIDENTAL INJURY CLAIM FORM

Failure to complete the required sections may result in a delay in processing this claim.

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.

SECTION B: ACCIDENTAL INJURY PHYSICIAN'S STATEMENT

Complete **ONLY** if filing an **Accidental Injury Claim**.

PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME	MIDDLE INITIAL	PATIENT BIRTH DATE
			____/____/____

PHYSICIAN INFORMATION

PHYSICIAN'S NAME	PHONE NUMBER	FAX NUMBER
	( )	( )

ADDRESS	CITY	STATE	ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD 9	DIAGNOSIS DESCRIPTION	PROCEDURE CODE (CPT)	PROCEDURE DESCRIPTION
____/____/____				
____/____/____				
____/____/____				
____/____/____				

FOR ACCIDENT CLAIMS: DID THIS ACCIDENT OCCUR AT ☐ HOME OR ☐ WORK?

Date of incident: _____/_____/_____

Describe where and how the incident occurred: ____________________

____

Was patient hospitalized as a result of this diagnosis? ☐Yes ☐No

Admission: _____/_____/_____

Discharge: _____/_____/_____

Hospital Name: ____________________ City: ____________ State: ____________

____________________ PHYSICIAN SIGNATURE

____________ DATE

____________________ TAX ID NUMBER

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SICKNESS CLAIM FORM

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SECTION C: SICKNESS CLAIM STATEMENT OF LOSS

Completed by claimant and **ONLY** if filing a **Sickness Claim.**

PATIENT LAST NAME	PATIENT FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH _____/_____/_____
Date of onset of sickness/symptoms: _____/_____/_____		Date first consulted physician: _____/_____/_____	
Nature of sickness:			
Have you ever had this condition before? ☐Yes ☐No		If yes, when?	
If hospitalized, when? From _____/_____/_____to _____/_____/_____			
Hospital name:		City:	State:
Are you covered under any other sickness disability programs? ☐Yes ☐No		If yes, please attach a list of company names.	
Are you currently doing anything for wage or profit? ☐Yes ☐No		If yes, monthly income: $	
List specific job duties that you can not perform.			

SECTION D: SICKNESS CLAIM PHYSICIAN'S STATEMENT

Completed by physician's office and **ONLY** if filing a **Sickness Claim.**

PHYSICIAN'S NAME	SPECIALTY	PHONE NUMBER ( )	TAX ID #	
ADDRESS		CITY	STATE	ZIP
PRIMARY/FAMILY PHYSICIAN'S NAME	PHONE NUMBER ( )	TAX ID #		
ADDRESS		CITY	STATE	ZIP
Diagnosis:			Diagnosis Code:	
When did patient first consult you for this condition? _____/_____/_____		Date of most recent examination: _____/_____/_____		
Has patient ever had same or similar condition? ☐Yes ☐No		If yes, when?		
Describe any other disease or infirmity affecting present condition:				
Please list patient's last known:	Weight	Height		
Was patient hospitalized solely due to this condition? ☐Yes ☐No		Where?		
Admission Date: _____/_____/_____	Discharge Date: _____/_____/_____			
Was patient disabled? ☐Yes ☐No	☐ Total Disability ☐ Partial Disability			
First date of disability: _____/_____/_____	End date of disability: _____/_____/_____	Date returned to work: _____/_____/_____		
Please list any procedure codes associated with the diagnosis indicated above. Attach a copy of the bill for services you rendered to this patient.	A)	B)	C)	
Please list the objective disability factors (disabling signs & symptoms): If length of this disability period exceeds normal duration for this diagnosis, please attach copies of all supporting documentation.				
Is the patient's past medical history on file in your office? ☐Yes ☐No		What years are available?		

COMPLETED BY (PRINT)	POSITION	DATE	PHYSICIAN'S SIGNATURE

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FRAUD WARNINGS **February 28, 2006**

AK / DE residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR residents: 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 is guilty of a crime and may be subject to fines and confinement in prison.

CA 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.

CO 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

DC residents: Warning: 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, the insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

ID residents: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LA residents: 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 is guilty of a crime and may be subject to fines and confinement in prison.

MN residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NM residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

ME / TN / VA 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 may include imprisonment, fines or a denial of insurance benefits.

NH 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 RSA 638:20.

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NJ residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

OH /OR 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 is guilty of insurance fraud.

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

PA 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.

PR residents: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars no more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

All other states residents: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

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