

# Claims Filing Instructions-Accident Policy

Following these instructions will avoid unnecessary delays in claim processing
Please provide the following information

- Please complete the attached Supplement Health Claim Form and Authorization and submit with your claim. If the accident was related to a motor vehicle accident we need a copy of the MVA Report.
- In some cases we may require a more detailed statement about the circumstances of the accident. If so, we will notify you.
- An itemized statement showing the full name, address and Tax ID number of the provider of service. This itemized statement should include the patient's name, date of service and amount charged for each service
- The diagnosis (ICD) code for each date of service and the procedure (CPT or HCPCS) code for each service rendered

If you have any questions please call our Customer Service Department at 800-552-7879 extension 1331.

Completed Claim Forms and claims can be mailed or faxed to our offices.

Philadelphia American Life Insurance Company Attention: Claim Department PO Box 4884 Houston, TX 77210-4884

Fax: 281-368-7382



## **Supplemental Health** Claim Form

#### **INSTRUCTIONS:**

- Please make sure all questions on this page are answered completely.

  Sign and date the authorization on page 2. Please return a copy to us along with the completed claim form. You may want to retain a copy for your records.
- Please attach itemized hospital bills, physician bills and other documentation of expenses. Make sure all bills indicate a diagnosis code, procedure code, date of service and cost. Prescription receipts must furnish date, patient name, name of medication and name of prescribing physician. Original bills must be submitted. If you make photocopies they should be retained for your files.
- For Cancer claims include the pathology report confirming the diagnosis of cancer.

Primary Insured's Full Name					
Full Address  ☐ Check if this is a new address				Daytime Telephone Number ()	
				Date of Birth/ Relationship to Insured	
If claim is for a child, please mark all that apply:				Date of Birdi// Relationship to insured	
	marr			e for tax purposes according to the US Internal Revenue Code	
l Fu	ll-tim	e stu		the number of hours per semester	
En	ploy	ed ful	Il time. Provide employer's name and address	verage(s) for which you are filing a claim:	
			☐ Cancer/Specified Disease ☐ Intensive Care		
SICKNESS	1.	a.	Condition claim is being filed for	a.	
		b.	Date symptoms first noticed	b/	
		c.	Date first saw physician for symptoms	c/ Still being treated? Yes / No	
		d.	Name and address of first physician seen	d	
		e.	Names and addresses of other physicians seen	e	
S					
		f.	Has patient ever had this or similar	f. Yes / No Date/	
		cc	condition before? If yes, give details.	Details	
	•				
CCIDENT	2.	a.	Explain the injuries and how the accident happened (If due to a motor vehicle	a	
			accident, attach a copy of the police report)	L / / Time AM / DM	
		b.	Date and time of the accident	b/ Time: AM / PM	
V		c.	Name and address of treating physician	c	
	3. Has the patient had other medical treatm		as the patient had other medical treatment uring the last five years? Describe conditions,	Yes / No	
		names of physicians consulted, their addresses and			
		da	ates seen.		
		т:			
	4.		st the name and address of your regular or nily physician		
	5	. Was patient hospitalized? If yes, give dates, name and address of hospital	Yes / No Hospital City State		
		<b>U</b> 41		Admit/ Time:AM / PM	
				Discharge / / Time : AM / PM	
				are true and correct. WARNING: Any person who knowingly presents a false	

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Primary Insured's Signature

Patient's Signature (if minor, parent signs)

Date



Signature

P.O. Box 4884, Houston, TX 77210 (800) 713-4680

### **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION**

Applicant / Primary Insured Name Po	olicy / Certificate # (if applicable)	Phone #
Address (Street, City, State, Zip)		
Protected Health Information (PHI) to be Used and/or history, medical examinations, services rendered, or tremental or emotional disorders, AIDS (Acquired Immune	eatment given, including treatme	ent for alcohol abuse, substance abuse,
Entities or Persons Authorized to Use or Disclose: U.S Medicare & Medicaid Services and any contractors of health care professional, hospital or other health care medical or medically related facility or professional.	or agents, including Medicare	intermediaries), any physician or other
Entities or Persons Authorized to Receive: Philadelphia designees, or representatives, including my PALIC age		pany (PALIC) or its agents, employees,
<u>Purpose of this Authorization</u> : By signing this form, you Information (PHI) to determine if your application will This authorization is a condition of your approved application.	be approved for health insurar	nce or that you are eligible for benefits.
You also will authorize PALIC to obtain your Protected determine payment of a claim for specified benefits invo		n other covered entities so that we may
Effect of Declining: If you decide not to sign this a insurance or to provide benefits.	uthorization, we may decline	to approve your application for health
This authorization may facilitate our consideration of processing of a claim.	a claim. If you decide not to s	sign this authorization, it may delay the
Effect of Granting this Authorization: The PHI to be use which case it would no longer be protected under the H		oject to re-disclosure by the recipient, in
Expiration: This authorization will expire upon the termination	nation of any PALIC coverage t	hat may be in effect.
Right to Revoke: I understand that I may revoke this Philadelphia American Life Insurance Company, P.O. E		
I understand that revocation of this authorization will no PALIC received my written notice of revocation.	ot affect any action PALIC took	in reliance on this authorization before
I have had full opportunity to read and consider the authorization, I am confirming my authorization of the ι in this authorization.		
Print Name of Applicant or Claimant	Signature of Applicant or Claimant (pa	arent if minor) Date
If this authorization is signed by a personal representati		
Personal Representative: Print Name	Please indicate Representative's relabriefly describe Representative's aut	

A photocopy of this authorization is as valid as the original, and you and your PALIC agent or broker are entitled to receive a copy of this form.

Date



# **STATE FRAUD WARNING NOTICES**

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.
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.
For your protection California law requires the following to appear on this form: 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
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.
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony
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.
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
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.
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.
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.
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Any person who, with a 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.
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
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 civil fines and criminal penalties
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.
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.
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.
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 insurance fraud.
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.
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years
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.
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.