PHILADELPHIA
AMERICAN
LIFE INSURANCE COMPANY

GAP Claims Filing Instructions

Following these instructions will avoid unnecessary delays in claim processing

- *When you receive treatment always present your ID card. Most providers of service will file your claim for you after your primary carrier has paid. If the provider files for you they will typically request that you assign benefits.*
- *If a provider will not file for you please follow the remaining instructions.*
- *Provide 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, amount charged for each service, the diagnosis (ICD) code for each date of service (3 to 8 digit code number) and the procedure (CPT or HCPCS) code for each service rendered (5 digit code number)*
- *An Emergency Room or Outpatient Hospital bill should include the Revenue Codes which are the 3 digit codes that indicate the charges for services rendered in each department of the hospital.*
- *We must have copies of the primary carrier Explanation of Benefits (EOB).*
- *If the claim is incurred in the first 12 months of coverage please complete the attached Claim Form and Authorization and submit with your claim. When submitting a claim that is incurred after your policy has been in force for 12 months you will not need to complete this form unless your claim is for an accident.*
- *If the claim is for an accident please complete the attached Claim Form and Authorization. If the accident was related to a motor vehicle accident we need a copy of the MVA Report.*
- *If a claim form is not required as indicated above, please make sure the insured name, the patient name and the policy number is included on all documentation submitted.*

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

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 4884 – Houston, TX 77210-4884

Supplemental Health Claim Form

INSTRUCTIONS:

1. Please make sure all questions on this page are answered completely.
2. 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.
3. 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.
4. For Cancer claims include the pathology report confirming the diagnosis of cancer.
5. For Specified Disease claims include the diagnostic test/lab results confirming the diagnosis of the disease.

Primary Insured's Full Name_____ Policy Number _____

Full Address _____Daytime Telephone Number (_____)_____

□ Check if this is a new address

Patient's Full Name_____ Date of Birth ___/___/____ Relationship to Insured _____

If claim is for a child, please mark all that apply:

☐ Unmarried ☐ Qualified as a dependent of you or your spouse for tax purposes according to the US Internal Revenue Code

☐ Full-time student over the age of 18. Provide the name of school and the number of hours per semester _____

☐ Employed full time. Provide employer's name and address _____

Type of coverage(s) for which you are filing a claim:

☐ Cancer/Specified Disease ☐ Intensive Care ☐ Critical Illness ☐ Hospital Indemnity ☐ Accident ☐ Other

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. _____
	f. Has patient ever had this or similar condition before? If yes, give details.	f. Yes / No Date ____/____/____ Details_____
ACCIDENT	2. a. Explain the injuries and how the accident happened (*If due to a motor vehicle accident, attach a copy of the police report)*	a. _____
	b. Date and time of the accident	b. ____/____/____ Time _____:_____ AM / PM
	c. Name and address of treating physician	c. _____
	3. Has the patient had other medical treatment during the last five years? Describe conditions, names of physicians consulted, their addresses and dates seen.	Yes / No _____
	4. List the name and address of your regular or family physician	
	5. Was patient hospitalized? If yes, give dates, name and address of hospital	Yes / No _____ Hospital City State Admit ____/____/____ Time ____:_____ AM / PM Discharge ____/____/____ Time ____:_____ AM / PM

I certify that the statements and answers on this claim form are true and correct. WARNING: 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. I also certify that I have read my current residential state fraud warning on the attached

- **Claim Fraud Warning page if my state is listed on that page.**

Patient's Signature (if minor, parent signs) _____ Date _____

Primary Insured's Signature _____ Date _____

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

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

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Applicant / Primary Insured Name | Policy / Certificate # (if applicable) | Phone #

Address (Street, City, State, Zip)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist, Pharmacy Benefit Manager or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Philadelphia American Life Insurance Company (PALIC) or its agents, employees, designees, or representatives, including my PALIC agent or broker.

Purpose of this Authorization: By signing this form, you will authorize PALIC to use and/or disclose your Protected Health Information (PHI) to determine if your application will be approved for health insurance or that you are eligible for benefits. This authorization is a condition of your approved application for our health insurance or your eligibility for benefits.

You also will authorize PALIC to obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining: If you decide not to sign this authorization, we may decline to approve your application for health insurance or to provide benefits.

This authorization may facilitate our consideration of a claim. If you decide not to sign this authorization, it may delay the processing of a claim.

Effect of Granting this Authorization: The PHI to be used and/or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any PALIC coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Philadelphia American Life Insurance Company, P.O. Box 34952, Omaha, NE 68134-9832.

I understand that revocation of this authorization will not affect any action PALIC took in reliance on this authorization before PALIC received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

Print Name of Applicant or Claimant | Signature of Applicant or Claimant (parent if minor) | Date ____/____/____

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name | Please indicate Representative's relationship to Applicant/Insured and briefly describe Representative's authority to act for Applicant/Insured.

Signature | Date _____/____/_____

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.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

STATE FRAUD WARNING NOTICES

ALASKA	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.
ARIZONA	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.
CALIFORNIA	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
COLORADO	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.
DELAWARE	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
FLORIDA	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.
IDAHO	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
INDIANA	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.
KENTUCKY	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.
LOUISIANA	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.
MAINE	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.
MARYLAND	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.
MINNESOTA	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NEW HAMPSHIRE	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.
NEW JERSEY	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW MEXICO	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
NEW YORK	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.
OHIO	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.
OKLAHOMA	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.
OREGON	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.
PENNSYLVANIA	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.
PUERTO RICO	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
TENNESSEE, VIRGINIA AND WASHINGTON	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.
WEST VIRGINIA	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.