# Claim Forms

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## Policyholder Claim Form
## Authorization for Use of Health-Related Information Form
## Authorization for Disclosure of Health-Related Information Form

Please submit all of these forms together. Please be aware that the Authorization for Disclosure of Health-Related Information Form is only required if you would like us to be able to speak to someone other than you about your care. Otherwise, that form does not need to be returned. **No benefits will be provided until itemized invoices are received by us from either the policyholder or the caregiver(s). We will not be obtaining invoices on your behalf.**

Completed forms should be mailed or faxed to:

**Senior Health Insurance Company of Pennsylvania**
P.O. Box 64913
St. Paul, MN 55164
**Fax:** 952-983-5256

Senior Health Insurance Company of Pennsylvania

# POLICYHOLDER CLAIM FORM

1. List ALL policy numbers under which you want to file a claim:
   Policy Number:_____ Policy Number: _____
   Policy Number:_____ Policy Number: _____
2. Policyholder's Name (Claimant):_____ Social Security #:_____-_____-_____
   Date of Birth:___/___/_____(MM/DD/YYYY) Gender: ❑ MALE ❑ FEMALE Phone Number: (___)____- _____
   Current Address:_____ City:_____ State:_____ Zip: _____
   What type of residence is this? ❑ Private Residence ❑ Nursing Home
   ❑ Assisted Living Facility ❑ Other: _____
3. Address to which all policy correspondence, including claim payments, should be mailed:
   ❑ Same as above ❑ Address shown below:
   Address:_____ City:_____ State:_____ Zip: _____
4. Cause or condition that caused you to require long-term care services: ❑ Sickness ❑ Accident
   _____
   _____
5. Date of the onset for this sickness or accident:___/___/_____(MM/DD/YYYY)
6. Is this claim related to an accident and someone else appears to be at fault? ❑ YES ❑ NO
7. Date you first sought treatment for this condition:___/___/_____(MM/DD/YYYY)
   Name of first treating physician: _____
   Address:_____ City:_____ State:_____ Zip: _____
   Phone Number: (_____)_____-_____ Fax Number: (_____)_____- _____
8. Is the physician above your family or primary care physician? ❑ YES ❑ NO
   If NO, please provide your family or primary care physician information:
   Family/Primary Care Physician Name: _____
   Address:_____ City:_____ State:_____ Zip: _____
   Family/Primary Care Physician Phone Number: (_____)_____-_____Fax Number: (_____)_____- _____
9. Privacy Laws restrict the information we can release to anyone other than the policyholder.
   **NOTE: IF YOU HAVE DESIGNATED A POWER OF ATTORNEY, PLEASE ATTACH THE DOCUMENTATION.**
   Have you designated a POWER OF ATTORNEY? ❑ YES ❑ NO
   Primary person to whom you have given POWER OF ATTORNEY: _____
   Home Number: (_____)_____- _____ Office: (_____)_____- _____ Cell: (_____)_____- _____
   **IF YOU HAVE DESIGNATED SOMEONE TO ACT ON YOUR BEHALF IN FILING THIS CLAIM, PLEASE ALSO COMPLETE THE "AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION" FORM.**
   Have you designated someone to act on your behalf? ❑ YES ❑ NO
   Person designated to act on your behalf in filing this claim: _____
   Home Number: (_____)_____- _____ Office: (_____)_____- _____ Cell: (_____)_____- _____

Senior Health Insurance Company of Pennsylvania

# POLICYHOLDER CLAIM FORM

10. Agency/Facility/Provider Name:_____ Provider Tax ID Number: _____

    Address:_____ City:_____ State:_____ Zip: _____

    Phone Number: (_____)_____-_____ Fax: (_____)_____-_____ Cell: (_____)_____- _____

    **NOTE: PLEASE ATTACH COPIES OF THE LICENSE OR CERTIFICATION, IF AVAILABLE.**

11. Start of care date:___/___/_____(MM/DD/YYYY) End of care date:___/___/_____(MM/DD/YYYY)

12. Was any period of the patient's care covered by Medicare? ❑ YES ❑ NO

    If YES, please list the dates: _____

13. Was the care preceded by a hospital stay? ❑ YES ❑ NO

    If YES, please provide admission and discharge dates: _____

    Hospital Name: _____

    Address:_____ City:_____ State:_____ Zip: _____

    Phone Number: (_____)_____-_____ Fax Number: (_____)_____- _____

14. Since the date care started, have there been any breaks in care? ❑ YES ❑ NO

    If YES, please provide explanation and dates:

    _____

    _____

    _____

    _____

**Before signing this form, please read the Claim Fraud Warning Statements for the state where the insurance policy was issued.**

**By signing below, I declare that all of the answers given are complete and true to the best of my knowledge and belief. I understand that Senior Health Insurance Company of Pennsylvania reserves the right to require further proof. By signing below, I agree that I have read and understand the applicable Claim Fraud Warning Statements.**

Policyholder or Legal Representative Signature:_____ Date: _____

**FRAUD 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.**

**The fraud warnings listed below are applicable to those policyholders with policies issued in the states and/or territories of AL, AK, AZ, AR, CA, CO, DE, DC, FL, ID, IN, KY, LA, ME, MD, MN, NH, NJ, NM, NY, OH, OK, OR, PA, PR, RI, TN, TX, VA, WA, and WV. Please review the fraud warning applicable to you before submitting a claim.**

**AL:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**AK:** 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:** 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, LA, RI, TX and WV:** 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:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

**CO:** 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.

**DE, FL, ID, IN and OK:** WARNING: 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.

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

**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.

**ME, TN, VA and WA:** 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.

**MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

**NH:** 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.

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

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

**NY:** 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.

**OH:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

**OR:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement material to the risk may be guilty of insurance fraud.

**PA:** 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:** 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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are 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.

# AUTHORIZATION FOR USE OF HEALTH-RELATED INFORMATION

**(This authorization complies with HIPAA Privacy Rules.)**

| | |
|---|---|
| Name of Policyholder: | Policy Number: |
| Address Line 1: | Address Line 2: |
| City, ST, Zip: | Date of Birth: _____/ _____/ _____ |

**NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.**

**Use of Health-Related Information *to* Senior Health Insurance Company of Pennsylvania (In Rehabilitation)**

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, pharmacy, pharmacy benefits manager, federal, state or local government agency, insurance or reinsuring company, third-party claims administrator, consumer reporting agency, employer, Medical Information Bureau (MIB) or any other organizations, institutions or persons with knowledge or records of me and my health, including but not limited to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to Senior Health Insurance Company of Pennsylvania (In Rehabilitation) ("the Company"), or its legal representative. I understand that information obtained by use of this authorization, including individually identifiable health information, may be used for the purpose of administering my insurance benefits and/or making eligibility, risk or claim determinations, and that this information may be transferred to any organization or person employed by or representing the Company to assist with this purpose. I understand that information disclosed under this authorization may include medical records and reports concerning my physical or mental health and any and all associated diagnoses, prognoses, care or treatments, diagnostic and laboratory tests, prescription drug information and history, and information regarding drug use, alcoholism, mental illness, sexually transmitted diseases, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company or their authorized administrator and may no longer be protected by the same rule that applied in the first instance. This authorization is valid while my claim is pending, while it remains active or in order for the Company to process my appeal or administer benefits. Except in the case of an appeal, this authorization shall expire on the date my claim ends or seven years from the date of my signature below, whichever is later. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I understand that my authorization is voluntary and that I can refuse to sign this authorization. I do understand, however, that failure to sign this authorization may impair the Company's ability to evaluate my claim and may be a basis for denying a claim for benefits. I further understand that I have the right to revoke this authorization by notifying the Company in writing at Senior Health Insurance Company of Pennsylvania (In Rehabilitation), *Attn: Claim Review,* PO Box 64913, St Paul, MN 55164. Such revocation may be the basis for denying benefits.

**IMPORTANT:** Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act on behalf of the insured (please check box, if applicable):

Legal Representative Power of Attorney Guardianship Conservatorship

# AUTHORIZATION FOR DISCLOSURE OF HEALTH-RELATED INFORMATION

**(This authorization complies with HIPAA Privacy Rules.)**

| | |
|---|---|
| Name of Policyholder: | Policy Number: |
| Address Line 1: | Address Line 2: |
| City, ST, Zip: | Date of Birth: _____/ _____/ _____ |

**NOTE: If this form is completed by a Legal Representative then a valid Power of Attorney, Guardianship, Conservatorship or similar documentation must accompany this form.**

**Health Information to be Disclosed *by*** Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
I authorize the Company to disclose my Protected Health Information to the following

(Person/Organization Receiving Information):_____

_____

The Relationship of this person/organization to me is: _____

This recipient may use the health information authorized on this form for the following purpose(s):

_____

_____

This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by giving written notice to: Senior Health Insurance Company of Pennsylvania (In Rehabilitation)*, Attn: Claim Review,* PO Box 64913, St Paul, MN 55164. I understand that the Company may not deny me benefits due to refusal to sign this authorization. I further understand that my signature on this form does not authorize any changes to my policy information or to my policy or change the way the Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The undersigned is entitled to receive a copy of this form. A photocopy of this authorization shall be as valid as the original.

Policyholder (or Legal Representative)

Signature: X _____ Date: _____

Type of authority to act or sign on behalf of the policyholder (please check box, if applicable):

☐ Legal Representative ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship