RESERVICING CLAIM FORM
"Policy Endorsement"

Policyholder Information

Name and Address: ______________________ ______________________		Social Security Number: ________/______/________
DOB: ______________	Policy Number(s): ______________________	

I believe I have had my claims denied based upon the "Policy Endorsement": ☐ Yes ☐ No
I did not file my claims due to the definition of Home listed in the "Policy Endorsement": ☐ Yes ☐ No

Claim Information

Date of Claim(s):	Provider of Services:
______________________	______________________
______________________	______________________
______________________	______________________

Please provide all pertinent information possible with regard to your claim:

____
____
____
____
____
____
____
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____
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____
____

Please submit the required documents to P. O. Box 64913 St. Paul, MN 55164 or fax to 952-983-5256.

______________________	______________________	__________
Printed Name	Relationship to Policyholder	Date

____
Signature

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-451-5824

CLAIM FORM

The patient or responsible person must complete Page 1 in full and sign.
Then the physician must complete and sign Page 2 and the provider of services must complete and sign Page 3.
The patient or the provider should attach a complete copy of the itemized billing statement. We do not pay for advance billing.
See Page 4 for instructions on how to file your claim.

PATIENT'S CLAIM FORM

1. LIST ALL POLICY/CERTIFICATE NUMBERS ____

2. SOCIAL SECURITY NUMBER: ____

DATE OF BIRTH: ____________________________

3. PATIENT'S NAME & ADDRESS – IF ADDRESS IS NEW, PLEASE CHECK BOX ☐ PHONE: (____) ________________

____

4. DATE YOU FIRST BECAME ILL OR DATE OF ACCIDENT
MO ____ DAY ____ YEAR _______

5. DATE YOU FIRST SAW ANY DOCTOR FOR THIS CONDITION
MO ____ DAY ____ YEAR ________

6. FAMILY OR PRIMARY CARE DOCTOR'S NAME & ADDRESS ____

____

I authorize any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as 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 the particular company to which I am submitting a claim, or to its legal representative. I understand that the information obtained by use of this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Senior Health Insurance Company of Pennsylvania to assist with this purpose.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid during the pendency of my claim and shall expire on the date my claim ends. 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 is as valid as the original.

Failure to sign this authorization may impair our ability to evaluate your non-health claim and may be a basis for denying a non-health claim for benefits. You have the right to revoke this authorization by notifying us in writing. Such revocation may be the basis for denying benefits.

Claimant Signature (or Legal Representative) ______________________
Date ______________________
Social Security Number ______________________

IMPORTANT – PATIENT PLEASE SIGN HERE

X ____________________________________ DATE______________________
(SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE)

IMPORTANT: IF A LEGAL REPRESENTATIVE IS ACTING ON BEHALF OF THE PATIENT, A VALID POWER OF ATTORNEY OR GURARDIANSHIP ORDER MUST ACCOMPANY THIS CLAIM FORM.

Legal Representative Name and Address ____

____

Legal Representative Phone Number (___) ______________________

Note: Providing claim information does not guarantee approval of a claim payment. All determinations will be based upon the claim information, policy language and rider(s), if applicable. Additional information may be required in order for a claim determination to be made.

PHYSICIAN'S CLAIM FORM

PLEASE ANSWER ALL QUESTIONS AND SIGN BELOW

1. **PATIENTS NAME:** ____

2. **PRIMARY CONDITION(S) CAUSING THIS LOSS:** ______________________________

____

____

3. **DATE OF FIRST TREATMENT FOR PRIMARY CONDITION:** MO ____ DAY ____ YEAR ________

   BY WHOM? (DOCTOR'S NAME & ADDRESS) ______________________________

____

____

4. **DATE OF PRIOR HOSPITAL STAY:** ____________ **DIAGNOSIS:** ____________

   HOSPITAL NAME & ADDRESS: ______________________________

____

____

MO ____ DAY ____ YEAR ________

5. **ANY NURSING HOME STAY OR IN-HOME CARE WITHING THE LAST 5 YEARS? YES____ NO_____ IF YES,**

   DATES: ____

____

   NAME AND ADDRESS OF PROVIDER OF CARE: ______________________________

____

____

6. **IS THERE A DIAGNOSIS OF COGNITIVE IMPAIRMENT? YES ____ NO____** **(If yes, please attach the results of any test used to determine this)**

ATTENDING PHYSICIAN'S CERTIFICATION

PHYSICIAN'S SIGNATURE ____________________ **DATE SIGNED** ____________________

PHYSICIAN'S NAME ____________________ **TAX ID#** ____________________

ADDRESS ____________________ **TELEPHONE# ( )** ____________________

CITY ____________ **STATE** ______ **ZIP** ________ **FAX# ( )** ____________________

PROVIDER CLAIM FORM

PLEASE ANSWER ALL QUESTIONS AND SIGN BELOW

1. **Patient Name :** ____

2. **Agency/Facility/Provider Name** ______________________

3. **Tax ID** ______________________

4. **Address**
____
____

5. **Phone Number**
(____)______________

6. **Fax Number**
(____)______________

7. **Type of license(s) held by the Agency/Facility/Provider of care:** ______________________
____

Date license(s) expires: ______________ **Please attach a copy of the license.**

8. **Was any period covered by Medicare?** **From** ________ **To** ________

From ________ **To** ________ **From** ________ **To** ________ **From** ________ **To** ________

9. **Was the care preceded by a hospital stay? Yes** _____ **No** _____ **If yes, dates**______________________
____

Hospital Name/Address: ______________________
____
____
____

Completed By ______________ **Position** ______________ **Date**______________

Phone Number (____)______________ **Fax Number** (____)______________

TO FILE A CLAIM

PATIENT/RESPONSIBLE PARTY

- Please make sure that page 1 is completed in full and signed.
- Once this is completed, please have your physician complete page 2 of the claim form in full. You may want to remind the physician's office that all questions should be answered to insure prompt servicing of your claim.
- When pages 1 and 2 are completed, the provider of the services should complete page 3. You or the physician can forward this to the provider.

PHYSICIAN

- Please verify that all of the questions are answered on page 2 to avoid delay in servicing your patient's claim. Once this is done, the form needs to be returned to the policyholder or forwarded to the provider whose services you are certifying to complete page 3.

PROVIDER

- Please verify that all of the questions are answered on page 3 and attach a copy of your license. Make sure to include the initial assessment, daily notes, the signed doctor's plan of treatment/certification and itemized bill.

WHEN ALL PAGES OF THE CLAIM FORM HAVE BEEN COMPLETE IN FULL, THE FORM, TOGETHER WITH ANY REQUESTED ATTACHMENTS FROM THE PHYSICIAN AND/OR PROVIDER AND ITEMIZED BILLS SHOULD BE MAILED TO:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164

FRAUD WARNING: 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.

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, an 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 any 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 RESIDENTS: 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 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.

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.

MD RESIDENTS: 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.

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 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.

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 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 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.

Acceptable Proof of Payment

Proof of payment may be provided in the form of cancelled checks (if copies, they must be prepared by your financial institution and include both the front and back of each check), bank statements showing payments for care, evidence of an electronic transfer of funds or payroll statements (showing gross wages and all applicable withheld amounts).