



# Claim Forms

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

Please submit all of these forms together. Please be aware that the Authorization for the Disclosure of Health Related Information 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

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# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MMDDYYYY) 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. The 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MMDDYYYY)

6. Is this claim related to an accident and someone else appears to be at fault?  YES  NO

7. The date you first sought treatment for this condition: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MMDDYYYY)

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

The 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: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_(MMDDYYYY) End of care date: \_\_\_\_/\_\_\_\_/\_\_\_\_(MMDDYYYY)

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that the information above is accurate and complete to the best of my knowledge.**

Policyholder or Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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 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, TX 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.

**DE, 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.

**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.

**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, RI RESIDENTS:** 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 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, WV 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, WA 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 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.

**OR, 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 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 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**

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** ("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, Attn: Claim Review, PO Box 64913, St. Paul, MN 55641**. 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 being 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

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, 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

Mail: Claims PO Box 64913, St. Paul, MN 55164 Fax: (952) 983-5256 Customer Service: (877) 450-5824 Page 4 of 4