




# Hospital Confinement/Outpatient Surgery Claim

 FAX this direction	<b>FAX this form: 1-800-880-9325</b> Or mail: P.O. Box 100195, Columbia, SC 29202	From:	
		Number of pages:	

## Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual(s) inquiring on my behalf.

**Note: Leave blank if you do not want anyone accessing your claim information.**

\_\_\_\_\_ Sales representative \_\_\_\_\_ Employer \_\_\_\_\_ Spouse, family member or significant other Name: \_\_\_\_\_

\_\_\_\_\_ I want Colonial Life to update me on the status of my claim through electronic messaging at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your phone.

\_\_\_\_\_ **Yes, I want ALL payment(s) for this claim sent by overnight delivery.** I understand payment(s) under \$100.00 cannot be sent overnight. I also understand that if I want my claim to be sent by overnight delivery, a **\$22.00 fee** will be deducted from my claim payment. This fee is subject to rate increases by carrier and does not include weekend delivery. **I understand that Colonial Life is unable to send overnight mail to a P.O. Box. I also understand that I must notify Colonial Life to discontinue this service.**

**Complete each section before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim.**

- If your name has changed, attach a copy of your driver's license or other legal documentation.
- Benefits are payable to you unless we receive written authorization to pay them elsewhere. This is called an assignment.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

**Type of claim you are filing:**  Diagnostic procedure  Emergency room  Hospital confinement/ICU  Rehabilitation  Surgical procedure

### Section 1 – Claimant statement (completed by policy owner)

Claimant name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: ____/____/____	SSN:
Relationship to policy owner: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent			
Policy owner information (if other than claimant)	Name:	DOB: ____/____/____	SSN:
Address:	City:	State:	ZIP:
Email:	Contact number:		
Primary physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Referring physician or hospital:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

### Section 2 – Accidental injury (completed by policy owner)

Please complete and attach itemized copies of any related bills including physician, ambulance, emergency room, hospital, and/or rehabilitation unit. Bills should include diagnosis information from your medical provider.

Date the accident occurred (not when it was treated): \_\_\_\_/\_\_\_\_/\_\_\_\_ Accident occurred:  On-job  Off-job

Have you been treated for the same or similar condition prior to this occurrence?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hospital admission:**  Yes  No

Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_  AM  PM Released: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_  AM  PM

Description of how the accident occurred (if auto accident, attach a copy of the accident report):

## Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others, require the following statement to appear on this claim form. **Fraud Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

**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, Rhode Island, Texas and West Virginia:** For your protection, California, Rhode Island, Texas and West Virginia 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.

**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.

**District of Columbia:** 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.

**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.

**Kentucky:** For your protection, Kentucky law requires the following to appear on this form: 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.

**Maine, 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 may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** 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.

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

**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 (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. If 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.

# Certification

Policy owner's name: \_\_\_\_\_ SSN: \_\_\_\_\_

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning:** 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.

_____	_____	_____
Print claimant's name	Claimant's signature	Date
_____	_____	_____
Print policy owner's name	Policy owner's signature	Date

## Section 3 – Hospital confinement/rehabilitation confinement (completed by physician)

**Please submit the following with your claim:** a copy of the itemized bill showing the admission and discharge dates and the daily room charges. If you are unable to provide billing statements, please have your doctor complete and sign the claim form.

Diagnosis/ICD codes:	Diagnostic procedure date: ____ / ____ / ____	Diagnostic procedure code/description:
Hospital:		Telephone:
Address:	City:	State: ZIP:
Admitting physician:		Telephone:
Address:	City:	State: ZIP:
Treating physician:		Telephone:
Address:	City:	State: ZIP:
<input type="checkbox"/> Hospital confinement and/or <input type="checkbox"/> Observation room: Admission date: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Date released: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Intensive care unit confinement: Admission date: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Date released: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Rehabilitation unit confinement: Admission date: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Date released: ____ / ____ / ____ Time: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<b>PREGNANCY</b>	If hospital confinement is for pregnancy or pregnancy complications, please provide:	Date first treated for pregnancy: ____ / ____ / ____
		Date of delivery: ____ / ____ / ____
		Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
		Surgical procedure code:

**Fraud warning:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

_____	_____
Signature of physician completing this form	Date (MM/DD/YYYY)

Physician name:	Patient account number:
Address:	City: State: ZIP:
Tax ID or SSN:	Telephone: Fax:
Will you accept the standard HIPAA release? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you accept medical record requests by fax? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require a special authorization for release of information? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization on file to release information to Colonial Life: <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Claimant name:</b>	<b>Claimant SSN:</b>
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**Section 4 – Surgery/diagnostic procedure (completed by physician)**

**Please submit the following with your claim:** a copy of the itemized surgeon’s bill showing the diagnostic/procedure codes and a copy of the operative report. If you are unable to provide billing statements, please have your doctor complete and sign the claim form.

<b>Surgery:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Admission: _____ / _____ / _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Released: _____ / _____ / _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>Surgery procedure description/code(s):</b>
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Anesthesia administered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia administered by a licensed anesthesiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is condition due to an accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Physician office visit(s) following surgery:**  
 1. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    2. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    3. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    4. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>Diagnosis/ICD codes:</b>	<b>Diagnostic procedures:</b> Date: _____ / _____ / _____ CPT Code: _____ Date: _____ / _____ / _____ CPT Code: _____
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**Fraud warning:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

_____ Signature of physician completing this form	_____ Date (MM/DD/YYYY)
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Physician name:	Patient account number:
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Address:	City:	State:	ZIP:
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Tax ID or SSN:	Telephone:	Fax:
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Will you accept the standard HIPAA release? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you accept medical record requests by fax? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you require a special authorization for release of information? <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization on file to release information to Colonial Life: <input type="checkbox"/> Yes <input type="checkbox"/> No
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## Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non-health information, including earnings or employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms, may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance. Some information once obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not re-disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier, and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to:

Colonial Life & Accident Insurance Company  
 Claims Department  
 P.O. Box 100195  
 Columbia, SC 29202-3195

I may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer my claim or eligibility for insurance.

**I am the individual to whom this authorization applies or that person's legal guardian, power of attorney designee, conservator, beneficiary or personal representative.**

\_\_\_\_\_ Signature \_\_\_\_\_ Date signed (MM/DD/YYYY)

\_\_\_\_\_ Printed name of individual subject to this disclosure  
 XXX-XX-\_\_\_\_\_ Last four digits of SSN  
 \_\_\_\_\_ Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as \_\_\_\_\_ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

\_\_\_\_\_ Printed name of legal representative  
 \_\_\_\_\_ Signature of legal representative  
 \_\_\_\_\_ Date signed (MM/DD/YYYY)