

# Helpful Hints

*From the Claims Department to guide you through filing your Hospital Indemnity claim*

We value you as a customer and want to make the process of filing a claim as fast and as simple for you as possible. To assist you with the process, we're providing these helpful hints:

## SUBMITTING A CLAIM

When submitting a claim, attention to the following details will assure that your claim moves quickly and benefits due are processed without delay.

- Submit a fully completed and signed claim form.
- Be sure to include the provider's name, address and phone number with all claims.
- Provide the first diagnosis date for the health condition for which bills are being submitted.
- Itemized bills are required that include dates of service, procedure codes and diagnosis codes before benefits can be considered (e.g. CMS 1500, UB04, etc.)

### TOP 3 REASONS CLAIMS MAY BE DELAYED

1. *Policy or certificate number* is not shown on the claim form and/or supporting documents.
2. The claim form is not completed in its *entirety*.
3. *Itemized bills* are not sent with the claim.

## WHERE TO SUBMIT CLAIMS

Mail all hospital indemnity *claims* to:

Claim Processing  
Conseco Companies  
P.O. Box 2024  
Carmel, IN 46082

*Express packages* should be addressed to:

Attn: Claim Processing 2024  
Conseco Companies  
11825 N. Pennsylvania Street  
Carmel, IN 46032

Faxes for the health claims should be sent to  
(317) 208-8656.

Phone calls may be directed to customer service at  
(800) 824-2726.

**Please note: Explanation of Benefits (EOBs) from another insurance company cannot be used to support your claim. Copies of the original bills must be submitted.**



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# HOSPITAL INDEMNITY CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.

**This form can be used for the following companies:**

Conseco Insurance Company    Conseco Life Insurance Company    Conseco Health Insurance Company  
 Washington National Insurance Company

POLICY OR CERTIFICATE NUMBER \_\_\_\_\_

SECTION A: OWNER INFORMATION (Please print)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE _ / _ / _	PHONE NUMBER (HOME) (   )
ADDRESS <span style="float: right;"><input type="checkbox"/> Check box if this is a new permanent address</span>		
CITY	STATE	ZIP
IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:		
PLACE OF EMPLOYMENT		PHONE NUMBER (WORK) (   )
ADDRESS		
CITY	STATE	ZIP
PATIENT INFORMATION (If different than owner; Please print)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE	PHONE NUMBER (   )
IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:		
PLACE OF EMPLOYMENT		PHONE NUMBER (WORK) (   )
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> CHECK IF DEPENDENT IS FULL-TIME STUDENT <input type="checkbox"/> CHECK IF INSURED IS DECEASED - DATE DECEASED   _ / _ / _

Please provide the names, addresses and phone numbers of any physician who has treated you or with whom you have consulted in the last five years:

\_\_\_\_\_

\_\_\_\_\_

**Please be sure to include the following information along with this claim form:**

**Itemized bills form from facility including diagnosis and/or procedure codes and charge amounts**

(Itemized bills may include but are not limited to the following claim forms: UB04, CMS 1500, etc.)

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of executing this form.

PATIENT'S SIGNATURE (or legal representative)	RELATIONSHIP	DATE
OWNER'S SIGNATURE (or legal representative)		DATE



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**For your protection, the laws of several states require the following statement:**

**Fraud Warning:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**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 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 Residents:** 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 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 any insurance company, 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 any 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.

**ME 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.

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

**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 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.

**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.



**NY Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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 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 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 may be guilty of insurance fraud.

**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.

**RI 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.

**TN 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 include imprisonment, fines and denial of insurance benefits.

**RI Residents:** 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 prison.

**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 include imprisonment, fines and denial of insurance benefits.

**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 include imprisonment, fines and denial of insurance benefits.

**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 fines and confinement in prison.



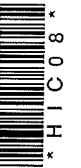
# Authorization to Release Information

Health Insurance Claims Processing--pursuant to the HIPAA Privacy Rule

<b>I. My information - the individual whose information will be released</b>		
Name:	Date of Birth:	Policy Number:
Address:		
<b>II. Disclosing Party - organization authorized to release my information</b>		
Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy or pharmacy-related organization, health plan or insurance company		
<b>III. Description of my information authorized for release</b>		
Any information related to my past, present or future medical care or treatment (including mental health, communicable disease, HIV/AIDS and substance abuse records, but excluding psychotherapy notes), unless specifically limited by me as follows: _____		
<b>IV. Purpose of release - describing how my information will be used by the Receiving Party after it is released</b>		
Processing my health insurance claim(s)		
<b>V. Duration of authorization</b>		
This authorization will expire 24 months from the date written below, unless I specify an alternate expiration date here: _____		
<b>VI. Receiving Party - organization that will receive my information</b>		
Conseco, Inc. and its affiliated insurance companies (Conseco Insurance Company, Conseco Health Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company, Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company and Colonial Penn Life Insurance Company)		
<b>VII. Approval - Signed and dated by me or my legal representative</b>		
<ul style="list-style-type: none"><li>■ I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to: CONSECO CLAIMS DEPT- PO BOX 2024 - CARMEL, IN 46082-2024</li><li>■ I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization</li><li>■ I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.</li><li>■ I understand that I am entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.</li></ul>		
Print Name: _____		Relationship: _____
Signature: _____		Date: _____
* Legal Representatives provide documentation of legal authority		
<b>VIII. Return signed and dated form</b>		
Conseco Claims Department, P.O. Box 2024, Carmel IN 46082-2024 Phone: (800) 541-2254 Fax: (317) 208-8656		



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# HOSPITAL INDEMNITY CLAIM FORM PHYSICIAN'S STATEMENT

**SECTION B: PHYSICIAN'S STATEMENT** Please answer each question COMPLETELY.

Failure to complete all sections may result in a delay in processing this claim.

Policy/Certificate Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Hospital Address: (Please include City and State) \_\_\_\_\_

**Hospitalization Information:**

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Was patient transferred from another facility?

1. Date of initial diagnosis: \_\_\_/\_\_\_/\_\_\_

2. Patient first consulted you for this condition on: \_\_\_/\_\_\_/\_\_\_

3. Was the patient referred to you by another physician?  Yes  No

If yes, physician's name: \_\_\_\_\_

Referring physician's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Please be sure to include the following information along with this claim form:

**Itemized bills from facility including diagnosis and/or procedure codes and charge amounts**  
(Itemized bills may include but are not limited to the following claim forms: (UB04, CMS 1500, etc.)

\_\_\_\_\_  
**Physician's Signature (or authorized hospital staff member**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Tax ID Number**

