Horace Mann | Wise

GROUP HOSPITAL INDEMNITY CLAIM FORM

1-888-950-1085
wisebenefits.com

The Certificate Holder must complete all sections below in full, and sign and date.
Unanswered or incomplete items can result in a delay in processing.

CERTIFICATE NUMBER

Instructions for filing a claim for benefits:
1. Certificate holder must complete sections A through G of the Claimant's Statement in full, and sign and date.
2. Certificate holder sign and date the HIPAA form.
3 Refer to your certificate for requirements for receiving specific benefits
4. When claiming Waiver of Premium due to disability, the Physician must complete section G and the Employer must complete section I.
5. Return all forms, itemized bills, and HIPAA to our Claims Processing Center.

CLAIMANT'S STATEMENT

Certificate holder must complete sections A through G of the Claimant's Statement in full, and sign and date.

A. Certificate Holder Information

NAME OF CERTIFICATE HOLDER		BIRTH DATE / /
ADDRESS		
CITY	STATE	ZIP CODE
PHONE ( ) -	ALTERNATIVE PHONE ( ) -	
EMAIL ADDRESS ☐ I would like to receive electronic correspondence concerning my claims and policies.		

B. Patient Information

PATIENT NAME			BIRTH DATE / /
RELATIONSHIP TO CERTIFICATE HOLDER	CITY		PHONE ( ) -
GENDER ☐ MALE ☐ FEMALE	HEIGHT (Feet and Inches)	WEIGHT (Pounds)	ALTERNATIVE PHONE ( ) -
SYMPTOMS FIRST OCCURRED ON:	FIRST DATE OF TREATMENT FOR THIS CONDITION:	WAS THE PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT? *IF YES, PLEASE SUBMIT COPY OF POLICE REPORT.*	

C. Claim Details

Complete the Injury or Sickness details based on the cause of your Hospital Confinement. Medical records may be requested.

FOR INJURIES ONLY:	FOR SICKNESS ONLY:
DATE OF INJURY:	DATE SYMPTOMS FIRST OCCURRED:
DESCRIBE HOW THE INJURY OCCURRED:	DATE OF FIRST TREATMENT FOR THIS CONDITION:
WHERE DID THE INJURY OCCUR: ☐ On the job ☐ Off the job	
WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT? ☐ Yes ☐ No *(If yes, please submit a Police Report, if available)*	

CERTIFICATE NUMBER

D. Inpatient Confinement Details

TYPE OF FACILITY ☐ Hospital ☐ Skilled Nursing Facility ☐ Inpatient/At Home Hospice ☐ Mental Health Treatment Facility ☐ Substance Abuse Treatment Facility		
ADMISSION DATE	DISCHARGE DATE	
HOSPITAL NAME	HOSPITAL PHONE NUMBER	
CITY	STATE	ZIP CODE

E. Outpatient Benefits

Please check the benefit you are claiming and include the itemized bill for each benefit checked from the options listed below.			
☐ Anesthesia	☐ Emergency Room	☐ Mental Health Treatment	☐ Physician's Office Visit
☐ Substance Abuse Treatment	☐ Surgery	☐ Therapy Services	☐ Urgent Care Benefit

F. Additional Benefits

Please check the benefit you are claiming and include the itemized bill for each benefit checked from the options listed below.		
☐ Ambulance	☐ Diagnostic Testing	☐ Durable Medical Equipment
☐ Family Member Lodging	☐ Prescription Medication	☐ Transportation Benefit

G. Authorization

By signing below, I represent that all information on this form is true and correct and that I have read the state-specific fraud warning on page 4.

(Signed) Patient _____ Date _____/_____/_____
A parent or legal guardian must sign if the patient is under the age of 18.

(Signed) Certificate Holder _____ Date _____/_____/_____

SEND THIS COMPLETED FORM TO OUR CLAIMS PROCESSING CENTER BY:

EMAIL: WiseClaimsMNL@horacemann.com **FAX:** 1-877-397-1152 **MAIL:** P.O. Box 365, Addison, TX 75001

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CERTIFICATE NUMBER

ATTENDING PHYSICIAN'S STATEMENT

When claiming Waiver of Premium due to disability, the patient's Physician must complete section H in full, and sign and date.

H. Waiver of Premium - To Be Completed by Physician

If claiming waiver of premium due to disability, the Physician is to complete the Information below. Instructions are included at the bottom of the page on how to submit the form to Wise Benefits.

DATE OF FIRST SYMPTOM (IF SICKNESS) OR DATE OF INJURY _____/_____/_____	DATE FIRST CONSULTED FOR THIS CONDITION _____/_____/_____	HAS PATIENT EVER HAD THE SAME OR SIMILAR SYMPTOMS? Yes ☐ No ☐ IF "YES" PLEASE GIVE THE DATE: _____/_____/_____
WAS THIS PATIENT REFERRED BY ANOTHER PHYSICIAN? ☐ YES ☐ NO	IF "YES," BY WHOM WAS THE PATIENT REFERRED? PLEASE INCLUDE CONTACT INFORMATION.	

NAME AND ADDRESS OF HOSPITAL WHERE SERVICES RENDERED (IF APPLICABLE)	DATE ADMITTED _____/_____/_____	DATE DISCHARGED _____/_____/_____

Diagnosis or Nature of Sickness or Injury	ICD-9 or ICD-10 Code
1.	
2.	
3.	

PROVIDER NAME	PROVIDER PHONE	PROVIDER FAX
PROVIDER ADDRESS		

PHYSICIAN PRINTED NAME	PHYSICIAN SIGNATURE	DATE SIGNED _____/_____/_____

EMPLOYER'S STATEMENT

When claiming Waiver of Premium due to disability, the patient's Employer must complete section I in full, and sign and date.

I. Waiver of Premium - To Be Completed by Employer

If claiming waiver of premium due to disability, the Employer is to complete the information below. Instructions are included at the bottom of the page on how to submit the form to Wise Benefits

DATE STOPPED WORK DUE TO DISABILITY _____/_____/_____	NAME OF EMPLOYER	EMPLOYER PHONE & FAX
DATE RETURNED TO WORK _____/_____/_____	EMPLOYER ADDRESS	

IS THE EMPLOYEE OFF WORK DUE TO DISABILITY THAT AROSE FROM EMPLOYMENT-RELATED ACTIVITIES?	IS THIS EMPLOYEE SEEKING BENEFITS UNDER WORKER'S COMPENSATION OR A SIMILAR EMPLOYER-SPONSORED PLAN
SIGNATURE AND TITLE OF OFFICIAL REPRESENTATIVE	DATE SIGNED _____/_____/_____

SEND THIS COMPLETED FORM TO OUR CLAIMS PROCESSING CENTER BY:

EMAIL: WiseClaimsMNL@horacemann.com **FAX:** 1-877-397-1152 **MAIL:** P.O. Box 365, Addison, TX 75001

STATE SPECIFIC FRAUD WARNINGS

Please review the following fraud warning for your state before signing the Claimant Statement on the previous page.

Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, Wisconsin, Wyoming - 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.

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

Colorado-Warning: 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 damage. 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.

Florida-Warning: 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.

Kansas-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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky-Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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-Warning: 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 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.

Maryland-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 may be guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire-Warning: 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.

New Jersey-Warning: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico-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 civil fines and criminal penalties.

Ohio-Warning: 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.

Oklahoma-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.

Pennsylvania-Warning: 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.

Tennessee & Washington-Warning: 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.

Texas-Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

Virginia-Warning: Any person who, with the 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 have violated state law.

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This Authorization Complies with HIPAA Privacy Rule

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, Pharmacy Benefit Managers, other medically related facilities, other insurance companies, and MIB, Inc.) to disclose all medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) and all pharmacy records to employees of Madison National Life Insurance Company, Inc. and affiliated entities (including its reinsurers) involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

Madison National Life Insurance Company, Inc. and affiliated entities may disclose my medical records, and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers) for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws. I also authorize Madison National Life Insurance Company, Inc. or its reinsurers to make a brief report of my protected health information to MIB.

I understand that I may revoke this Authorization in writing, except to the extent that Madison National Life Insurance Company, Inc. or an affiliated entity has acted in reliance upon this Authorization. My revocation in writing must be submitted to:

Madison National Life Insurance Company, Inc.
Attn: Director of Compliance
P.O. Box 365 • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization, and I agree that a copy of this Authorization is as valid as the original.

_____ _____

Signature of Individual Whose Information is to be Disclosed | Date

_____ _____

Printed Name of Individual | Certificate Number