Horace Mann | Wise

GROUP ACCIDENT 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.

Instructions for filing a claim for benefits:

1. Certificate holder must complete sections A through F of the Claimant's Statement in full, and sign and date.
2. Attending Physician required to complete sections G through M of the Attending Physician Statement, sign and date.
3. Certificate holder Sign and date the HIPAA form.
4. Return all forms, itemized hospital bill and Admission and Discharge Summary if confined as an Inpatient. Include surgeon's bills, as well as ambulance bill and police report if applicable. If treated in the emergency room, include the discharge papers from the hospital. Return all of the above to our Claims Processing Center.

Certificate #

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.	
EMPLOYER/GROUP ASSOCIATION NAME			

B. Patient Information

PATIENT NAME			BIRTH DATE / /
RELATIONSHIP TO CERTIFICATE HOLDER	CITY		PHONE ( ) -
GENDER ☐ MALE ☐ FEMALE	HEIGHT (Feet and Inches)	WEIGHT (Pounds)	ALTERNATIVE PHONE ( ) -
DATE FIRST TREATED BY PHYSICIAN FOR ACCIDENT		HAS THE PATIENT EVER BEEN TREATED FOR THE SAME OR SIMILAR CONDITION?	

C. Accident Details

Please provide a complete description of your accident. If the accident required a police report to be filed, attach a copy of the police or accident report.

DATE OF ACCIDENT	LOCATION OF THE ACCIDENT (CITY, STATE)

DESCRIBE HOW THE ACCIDENT HAPPENED (INCLUDE ADDITIONAL INFORMATION ON SEPARATE SHEET OF PAPER IF NEEDED)

Certificate #

Was the patient the driver in a motor vehicle accident? *(If yes, attach police report)*	☐ YES	☐ NO
Was the patient involved in any other type of accident that required a police report? *(If yes, attach police report)*	☐ YES	☐ NO
Was the patient at work when the Injury occurred? (If yes, attach copy of employer's injury report)	☐ YES	☐ NO

D. Checklist

Did you complete sections A, B, and C? *(If no, please explain below)*	☐ YES	☐ NO
Did a member of your family over the age of 18 incur charges for qualifying lodging in a motel or hotel while you were confined as an inpatient in a hospital more than 100 miles from your primary Residence as a result of your accident? *(If Yes, provide a copy of the lodging receipt)*	☐ YES	☐ NO
Did you or a member of your family incur charges for qualifying lodging in a motel or hotel for your treatment at a Hospital or Outpatient Care facility more than 100 miles from your primary Residence as a result of your accident? *(If Yes, provide a copy of the transportation receipt)*	☐ YES	☐ NO
Did you or your spouse incur an expense for a Dependent Adult Day Care Center in connection with a Hospital Confinement as a result of an injury? *(If Yes, provide a proof of the incurred expense)*	☐ YES	☐ NO
Did you incur an expense for a Dependent Child Care Center in connection with a Hospital Confinement as a result of an injury? *(If Yes, provide a proof of the incurred expense)*	☐ YES	☐ NO
Did you fill a prescription for a Prescription Medication for Treatment of an injury? *(If Yes, provide a proof of the incurred expense)*	☐ YES	☐ NO

E. 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 7.

(Signed) Patient _____ Date _____/_____/_____

(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

Next Steps

- Complete section F of the **Attending Physician Statement**
- Sign the **Authorization for Release of Health-Related Information**
- Provide the **Attending Physician Statement** to the treating physician for completion of sections G through M along with the signed **Authorization for Release of Health-Related Information**

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GROUP ACCIDENT CLAIM FORM

CERTIFICATE NUMBER

ATTENDING PHYSICIAN'S STATEMENT

Attending Physician required to complete sections G through K of the Attending Physician Statement, sign and date.

F. Patient Information (to be completed by the *patient*)

NAME OF PATIENT	PATIENT'S BIRTH DATE
EMPLOYER NAME YOUR COVERAGE IS WITH	
PHYSICIAN NAME	PHYSICIAN PHONE
☐ I authorize the release of any medical information necessary to process this claim.	
PATIENT SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

G. Listed Benefits (to be completed by the *physician*)

What type of injury(ies) did your patient sustain as a result of the accident reported on this claim form?
Please provide details on the page noted next to the injury, otherwise details can be provided on the bottom of this page. If additional space is needed, attach a separate sheet.

☐ Burn (Provide details on page 4)	☐ Laceration (Provide details on page 4)
☐ Coma	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Concussion	☐ Puncture
☐ Hernia	☐ Traumatic Brain Injury
☐ Herniated Disc	☐ Tendon, Ligament, or Rotator Cuff
☐ Fracture (Broken Bone - Provide details on page 4)	☐ Dismemberment/Catastrophic Loss (Provide details on page 5)
☐ Gunshot	☐ Torn Knee Cartilage
☐ Dislocation with closed reduction	☐ Dislocation with open reduction

What type of service did your patient receive as a result of the accident?

☐ Pain Management	☐ Physician's Office Follow-Up Treatment
☐ Urgent Care/Telemedicine Follow-Up Treatment	☐ Therapy Services
☐ Home Health Care	☐ Blood/Plasma/Platelets Blood Transfusion
☐ Emergency Dental	☐ Medical Appliance
☐ Prosthetic Device	

Please provide details that apply to your patient's claim.

Date of Service	Diagnosis Description	CPT Code	Procedure Description

CERTIFICATE NUMBER

Has the patient ever had the same or similar condition or injury? *(If Yes, state when and describe)* ☐ YES ☐ NO
Describe any other disease or infirmity affecting the patient's present condition and injury(ies).
Give dates of treatment, and nature of treatment other than surgical.
Name of Facility/Hospital where treatment was provided.

H. Burn (Check the box that applies)

☐ Minor Burns	☐ Moderate Burns	☐ Severe Burns	☐ Skin Graft

I. Fracture

Nature of Surgical procedure, if any. (Describe fully and give approach used even if more than one is used.	
DATE	Location/Description
	Approach Used (Closed/Open Reduction)
DATE	Location/Description
	Approach Used (Closed/Open Reduction)
DATE	Location/Description
	Approach Used (Closed/Open Reduction)

J. Laceration

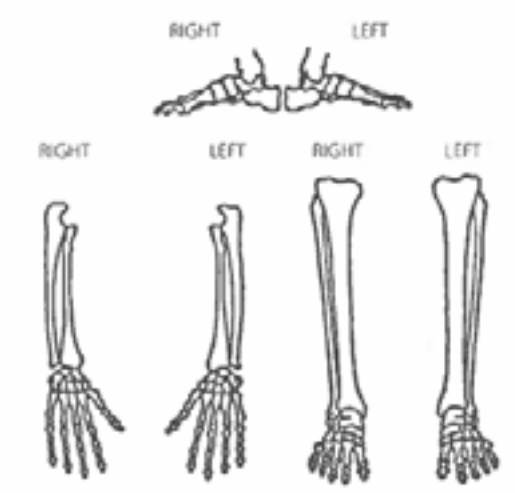
If the injury resulted in a laceration, provide details and method of repair:
☐ Laceration was repaired without stitches
☐ Laceration was repaired with stitches, sutures, or staples
☐ Total of all lacerations repaired is less than two inches (5.08 cm) long
☐ Total of all lacerations repaired is two inches to six inches (5.08 to 15.24cm)
☐ Total of all lacerations repaired over six inches (over 15.24cm)

CERTIFICATE NUMBER

K. Accidental Dismemberment - Catastrophic Loss

Please select the condition your patient has and provide details at the bottom of the page:	
☐ Loss of Both Hands or Both Feet	☐ Loss of Use of One Arm and One Leg
☐ Loss of Both Arms or Both Legs	☐ Total Blindness
☐ Loss of Use of Both Arms or Both Legs	☐ Loss of Hearing in Both Ears
☐ Loss of One Hand and One Foot	☐ Loss of Speech
☐ Loss of One Arm and One Leg	☐

For a dismemberment, which limb was severed or amputated?
For a functional loss or paralysis, please describe where the loss occurred.
State the dates on which the severance or amputation, functional loss or paralysis occurred.
State the cause of the severance/amputation/functional loss/paralysis.
If a limb was reattached, indicate the date of reattachment and functional outcome.



State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

CERTIFICATE NUMBER

L. Treatment History

Supporting documents related to the treatment of your patient's injury(ies) resulting from the accident reported to us in this claim form should include:

- Diagnosis
- Specific procedure or treatment the patient received
- Date of service
- Surgical reports (where applicable)
- Radiology/imaging or similar reports that summarize the nature of the injury in question
- Notes and summaries that outline any or all of the following based on the nature of the injury: follow up treatment, rehabilitation, or need of a medical appliance or device
- Date of accident resulting in injury(ies) for which you were consulted.
- The date(s) your patient first consulted you for injury(ies) resulting from the accident?
- Date of last treatment for the injury(ies)

M. Physician Signature and Contact Information

PHYSICIAN PRINTED NAME		DATE	
PHYSICIAN SIGNATURE		DATE	
SPECIALTY	FEDERAL TAX ID	PHONE	FAX
ADDRESS	CITY	STATE	ZIP CODE

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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