Helpful Hints

From the Claims Department to guide you through filing your Heart/Stroke 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 REASONS CLAIMS MAY BE DELAYED

1. *Policy* or *certificate number* is not shown on the claim form and/or supporting documents.
2. *Supporting documents* such as medical bills, death certificate, pathology report, etc. are not sent with the claim form.

WHERE TO SUBMIT CLAIMS

Mail all heart/stroke *claims* to:

Claim Processing
P.O. Box 2024
Carmel, IN 46082-2024

Express packages should be addressed to:

Attn: Claim Processing 2024
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) 541-2254.

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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HEART AND STROKE CLAIM FORM

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

Wilcac Life Insurance Company
P.O. Box 2024
Carmel, IN 46082-2024
(800) 541-2254

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	☐ Check box if this is a new permanent address	
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) ( )	
☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED ☐ OTHER	RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐ 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:

_____

_____

Transportation/Lodging Information: To be completed if you are filing a claim for transportation or lodging:

Date	To/From	Roundtrip Mileage	Type of Treatment

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

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

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FRAUD WARNING NOTICES
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: 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.

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

ALASKA, DELAWARE, FLORIDA, IDAHO: Your state requires us to notify you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA: 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.

ARIZONA, KENTUCKY, 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.

CALIFORNIA: For your protection California law requires the following warning statement to appear on this form: 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 state prison.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

DISTRICT OF COLUMBIA: 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.

HCF001(08/21)

INDIANA, MINNESOTA: Your state requires us to notify you that: any 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.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 HAMPSHIRE: Your state requires us to notify you that any person, 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 under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

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.

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 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 [be] 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.

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 include imprisonment, fines and denial of insurance benefits.

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Authorization to Obtain Medical/Confidential Information

Conforms to HIPAA Privacy Rule

1. My Information – the individual who is the subject of the information

Printed Name	Date of Birth	Social Security Number

Address	City	State	Zip

2. Disclosing Party – parties authorized to release information about me

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

4. Purpose of Authorization – how my information will be used

To administer benefits under a policy or certificate of insurance.

5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving Parties – parties authorized to receive information about me

CNO Services, LLC on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Wilcac Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company, Primerica Life Insurance Company, Jefferson National Life Insurance Company **domiciled in and licensed in the State of New York*

7. Important information – review carefully before signing

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service P.O. Box 2024, Carmel, IN 46082-2024.
- The Receiving Parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling 800-541-2254 to request form HEALTHMEDAUTH-LARGE.

8. Approval – must be signed and dated by me or my Legal Representative* to be valid

Printed Name	Relationship to the Insured

Signature	Date Signed

**Legal Representatives must provide documentation of legal authority*

Customer Service P.O. Box 2024 Carmel IN 46082-2024 – FAX 888-229-1414 – PH 800-541-2254

Authorization to Obtain Medical Records

Pursuant to the HIPAA Privacy Rule – to be obtained after insurance is issued

Important information about this Authorization to Obtain Medical Records

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment or the terms of my insurance coverage, but may prevent my insurance company from being able to determine when benefits are payable to me in the event I file a claim.
- I understand that I can revoke this Authorization at any time, except to the extent it has been relied upon, by sending a written revocation to the address below
- I understand if the person or organization that I authorize to receive information described in this Authorization is not subject to federal health information privacy laws then such information could be re-disclosed and would no longer be protected by these laws.
- I understand that I have a right to receive a copy of this Authorization.
- I understand that a photocopy or facsimile of this Authorization is as valid as the original.
- Return the signed and dated form to:

Customer Service
P.O. Box 2024
Carmel, IN 46082-2024

Phone (800) 541-2254
Fax (317) 208-8656

HEART AND STROKE 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: _____

Hospitalization Information:

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Was patient confined to Intensive Care Unit? ☐Yes ☐ No

If more space is needed, please attach a copy of the standardized claim form (UB04, CMS1500, etc). Please include Intensive Care Unit detail if applicable.

Admission Date	Discharge Date	Principle and Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state)	Was patient transferred from another facility?

Surgery/Anesthesia Information:

Did patient undergo surgery for this condition? ☐ Yes ☐ No If more space is needed, please attach acopy of a standardized claim form (UB04, CMS1500, etc.)

Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital

Name of facility: _____

Date of Service	Diagnosis/ICD Code	Surgery/CPT Code	Description of Surgery	Facility Name	Charges

Blood/Plasma Information:

Date Given	HCPCS/CPT Code	Number of units	Charges

(PHYSICIAN'S STATEMENT CONTINUED ON NEXT PAGE)

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

HEART AND STROKE CLAIM FORM
PHYSICIAN'S STATEMENT

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

Policy/Certificate Number: _____ Policyholder Name: _____
Patient Name: _____ Patient's Date of Birth: _____

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

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

Has the patient ever been diagnosed or treated for any of the following conditions?

Condition	Yes	No	CPT Code	Date	Condition	Yes	No	CPT Code	Date
Heart Attack					Arteriosclerosis				
Heart Disease					High Blood Pressure				
Heart Abnormality					Stroke				
Disorder of Coronary Arteries					If stroke, did stroke result in paralysis?				
Any other heart condition									

1. Date of initial diagnosis: ____/____/____

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

3 Was the patient referred to you by an other 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 the facilities that include the procedure and/or diagnosis codes and charge amounts (Itemized bills may include but are not limited to the following claim forms: UB04,CMS 1500, etc.)**

_____ _____ _____

Physician's Signature **Date** **Tax ID Number**

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