Washington National Insurance Company
Home office: 11825 N. Pennsylvania St., Carmel, IN 46032

**Questions about your claim submission?**
**Call (800) 541-2254**

# HOSPITAL INDEMNITY AND ICU CLAIM FORM

We want to make the process of filing a claim as fast and as simple as possible. We need specific information to process the claim:

- ✓ Patient information
- ✓ Date of service
- ✓ Charge amount
- ✓ CPT code or procedure description
- ✓ ICD code or diagnosis for treatment
- ✓ Itemized medical bills for treatment

This information is commonly found on itemized medical bills (e.g., CMS1500 or UB04 billing forms) or you can ask your Physician to provide this information on the enclosed Attending Physician's Statement.

**Note: Some benefits may require additional documentation.**

**WHERE TO SUBMIT CLAIMS:**

- ☐ ***Mail:*** Washington National Claims Department, P.O. Box 2024, Carmel, IN 46082-2024
- ☐ ***Express mail:*** Attn: Claim Processing 2024, 11825 N. Pennsylvania St., Carmel, IN 46032
- ☐ ***Fax:*** (888) 229-1414

| SECTION A: OWNER INFORMATION (please print) | | | |
|---|---|---|---|
| Policy or certificate number | | | |
| Last name | First name | Middle initial | |
| Date of birth | Social Security number | | |
| Mailing address ☐ Check box if this is a new permanent address ☐ Check box if address change applies to everyone on the policy | | | |
| City | State | ZIP code | |
| If mailing address is a P.O. Box, please indicate physical address here | | | |
| Email | | | |
| Home phone number | May we leave a voice mail here? | ☐ Yes | ☐No |
| Work phone number | May we leave a voice mail here? | ☐ Yes | ☐ No |

| SECTION B: PATIENT ADDRESS INFORMATION (if different from owner) | | |
|---|---|---|
| Last name | First name | Middle initial |
| Social Security number | Date of birth | Phone number |
| Mailing Address | | |
| City | State | ZIP code |

| SECTION C: PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Gender | Marital status | Relationship | | |
| ☐ Male | ☐ Single | ☐ Self | ☐ Spouse | ☐ Dependent |
| ☐ Female | ☐ Married | ☐ Check if dependent is disabled | | |
| | ☐ Other | ☐ Check if insured is deceased; date deceased ____/____/_____ | | |

**Reminder: Did you include these items?**

- ✓ Patient information
- ✓ Date of service
- ✓ Charge amount
- ✓ CPT code or procedure description
- ✓ ICD code or diagnosis for treatment
- ✓ Itemized medical bills for treatment

**Some services listed may not be covered by your policy. Please reference your policy for available benefits.**

By signing my name on this document, I declare that all 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 signing this form.

_____ _____ ____/____/_____

Patient signature (or legal representative) Relationship to owner Date

_____ ____/____/_____

Owner signature (or legal representative) Date

## SECTION D: PHYSICIAN STATEMENT
**To be completed and signed by the Physician**

***Please answer each question COMPLETELY. Failure to complete all sections may delay processing of this claim.***

| | |
|---|---|
| Policy or certificate number | Policyowner name |
| Patient name | Patient date of birth |
| Physician name | Physician phone number |
| Physician mailing address | |

1. Date of diagnosis ___/___/_____ 2. Patient first consulted you for this condition on ___/___/_____

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

If yes, referring physician name _____ Phone number _____

Referring physician address _____

**FACILITY INFORMATION:**
**(Please select all that apply)**

Inpatient Hospital ☐ Outpatient Hospital ☐ U.S. Government Hospital ☐ Rehabilitation Facility ☐

| Admission date | Discharge date | Admitting diagnosis/ICD code | Description of Surgery or CPT code | Charges | Was patient transferred to/from hospital by ambulance? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Please provide information regarding any additional services listed below**

| | Physician Office Visit | Laboratory Tests | Emergency Room or Urgent Care visit | X-ray or other Imaging Exams | Diagnostic Exams |
|---|---|---|---|---|---|
| Date(s) of Service | | | | | |
| Name of Exam(s) | | | | | |

_____ ___/___/_____ _____

Physician signature Date Tax ID number

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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.

**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, Wilco 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*

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