GREAT-WEST FINANCIAL

Hospital Indemnity Plan
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HOSPITAL COVERAGE CLAIM REPORT
MEMBER STATEMENT – PLAN #1117

INSTRUCTIONS: Complete all questions, date and sign Authorization Section and attach a copy of your itemized bill showing room and board charges. YOUR BILL MUST INCLUDE A DIAGNOSIS OR YOU MUST HAVE YOUR DOCTOR SUBMIT A STATEMENT VERIFYING YOUR DIAGNOSIS. If you do not have a bill to submit, contact the patient billing department at the hospital and request the itemized UB-04 form be sent to you. Please note: If you wish to file a claim for Critical Condition benefits separate claim forms are required.

1. Members Name: _____ 2. ADA No. _____

3. Sex: ☐ Male ☐Female 4. Date of Birth: ____/____/____

5. Home Address (No., Street, City, State, Zip): _____

_____

6. Home Phone Number: _(_____)_____ 7. Office Phone Number: _(_____)_____

If making a hospitalization claim for Spouse or Dependent, please list:

a.) Spouse / Dependent's Full Name: _____

b.) Relationship to member: _____

c.) Date of Birth: ____/____/____ d.) Sex ☐ Male ☐ Female

e.) Is Spouse / Dependent employed? ☐ Yes ☐ No

f.) Employer's Name and address: _____

g.) Is Dependent a full time student? ☐ Yes ☐ No

h.) Is Dependent married? ☐ Yes ☐ No

8. When did injury occur or when did illness commence? Date: ____/____/____ at: _____ AM/PM

9. Describe injury, illness, and/or medical reasons for your hospital visit by means of a diagnosis: _____

_____

10. Name, address and telephone number of all physician(s) treating this condition including Primary Care physician (Please attach additional pages if necessary) :

_____

_____

11. If hospitalized, give name, address and telephone number of hospital(s):

_____

_____

12. Dates of Service: 1) Start date ____/____/____ to: End date ____/____/____

2) Start date ____/____/____ to: End date ____/____/____

13. Has the person making claim ever received any medical treatment, care, advice or medication for the same or related condition? ☐ Yes ☐ No If yes, please provide details:

_____

_____

PLEASE SIGN AND DATE AUTHORIZATION ON BACK SIDE

HIPAA Compliant Authorization for Release of Medical Information

_____ ____/____/____

Name of insured/patient (please type or print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other health care professional that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West. This includes information on the diagnosis or treatment of Human Immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West.

This authorization shall remain in force for 36 months following the date of my signature below and a copy of this authorization is a valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be redisclosed by (the recipient) except as authorized by me or as required by law.

I understand that "My Providers" may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Great-West may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient