Group Retiree Health Insurance Claim Form

Claimant Responsibilities

1. Complete, date and sign this form (both pages 1 & 2). Use a separate form for each family member and for each accident, illness or service.

2. Provide all relevant supporting documentation, such as itemized medical bills (hospital, physician, ambulance, etc.), Medicare Explanation of Benefits (if applicable), and itemized receipts to help prove the claim. As an alternative, you may ask your providers to complete Step III of this form.

3. Submit the form and require documentation to

Address: WebTPA, PO Box 1928, Grapevine, T

or

Claims Fax# 469-417-1974

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Group Retiree Health Insurance Claim Form

THE HARTFORD

STEP I THIS SIDE MUST BE COMPLETED BY CLAIMANT. Please print or type.

Name of your former employer:	Policy Number:
Full Name of Member: (First, Middle, Last)	Date of Birth:
Full Name of Dependent: (First, Middle, Last)	Date of Birth:
Address: (Street, City, State & Zip Code)	
Email Address:	
Personal Cell Phone Number:	Alternate Telephone Number:

May we have your authorization to leave confidential medical and benefit information on your personal cell phone?

☐ Yes ☐ No

Signature: _____ Date: _____

This claim is for (check box): ☐ Hearing ☐ Vision ☐ Foreign Travel ☐ Other medical benefits

Description of services for which the claim is submitted:

Authorization to Release Information

I hereby authorize any hospital, physician, or other person who has attended me to furnish The Hartford with any and all information regarding my illness, medical history, consultations, prescriptions, or treatment and with copies of all hospital or medical records.

Patient's Signature: _____ Date: _____

(Parent or guardian must sign if patient is a minor)

STEP II Assignment of Benefits (Optional)

Complete this section ***Only*** when you wish payment to be made directly to the provider(s) of service. If more than one provider, complete a block for each.

Note: Tax Identification Number required for each provider of care listed.
I hereby authorize payment of all supplemental benefits to which my policy entitles me for this illness or injury to be made directly to the following provider(s) of care:

PROVIDER NAME (hospital, doctor, etc.)	PROVIDER NAME (hospital, doctor, etc.)	PROVIDER NAME (hospital, doctor, etc.)
STREET ADDRESS	STREET ADDRESS	STREET ADDRESS
CITY, STATE & ZIP	CITY, STATE & ZIP	CITY, STATE & ZIP
TAX NUMBER	TAX NUMBER	TAX NUMBER
PROVIDER TELEPHONE NUMBER	PROVIDER TELEPHONE NUMBER	PROVIDER TELEPHONE NUMBER

MEMBER SIGNATURE **X** _____ DATE **X** _____

Please be sure to read and sign page two of this form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of Colorado: 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 damages. 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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 by 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

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Patient's name: _____ Policy number: _____

Signature: _____ Date: _____

STEP III Statement of Attending Physician

(1) Diagnosis Code / Description

(2) Date symptoms first appeared or accident happened

(3) Date patient first consulted you for this condition

(4) Did condition require emergency care? ☐ Yes ☐ No

(5) Patient was hospital confined from _____ to _____

Name of hospital:

(6) Report of services.

DATE(S)	PLACE(S)	DESCRIPTION(S)	CHARGES

*(use codes)

O Doctor's Office
H Inpatient hospital
OH Outpatient Hospital
NH Nursing Home
OL Other locations

(7) ☐ I do accept assignment ☐ I do not accept assignment

Date | Physician's or Hospital's Name (Print) | Physician's Degree | Telephone Number

Physician's or Hospital Representative's Signature

Street Address

City or Town | State or Province | Zip Code

Social Security or Tax Identification Number _____
(required by law) (9 digit number)

PLEASE MAIL THIS COMPLETED FORM BACK TO:

WebTPA Claims
PO Box 1928
Grapevine, TX 76099-1928