

# Hospital Indemnity Insurance

## Claim Checklist



### To avoid unnecessary processing delays, make sure you have:

- A completed and signed Hospital Indemnity Claim Form**

Your policy has a six month pre-existing limitation and a two year policy contestability period. A claim happening during the first two years may require additional information. If we need to request additional information and have your signed Claims HIPAA Authorization for Release of Protected Health Information (PHI) form, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.
- A standardized Billing Statement (UB04 or HCFA) or an itemized billing statement including required information**
- A completed and signed Claims HIPAA Authorization for Release of Protected Health Information (PHI) form**

We suggest you keep a copy of all the information you send for your records.

You can submit your claims via the mobile app, mail or fax.



#### MyMedico Mobile App

Visit [gomedico.com/mobile-app](https://gomedico.com/mobile-app) to download



Medico Insurance Company  
P.O. Box 21660  
Eagan, MN 55121-0660



Fax: 402-496-8199

### Important Message

Failure to submit **ALL REQUIRED INFORMATION** may delay processing this claim. To prevent possible delays, make sure to complete the claim form and include required health care provider documentation to support the claim. Written notification will be provided if additional information is needed to process a claim.

### We're here for you



#### Medico Customer Success

800-228-6080

Monday-Friday, 7:30 a.m. to 5 p.m. Central time



#### Mobile: Manage your insurance on the go

With the free MyMedico mobile app, it's even easier to get the most out of your insurance benefits. Review your coverage, submit and check claims, view your ID card, find providers, and more, all with a few taps on your mobile device.

Learn more at

[gomedico.com/mobile-app](https://gomedico.com/mobile-app)



#### Customer portal

With Medico's secure customer portal, you can safely and conveniently manage your insurance policy online. You'll have 24/7 access to your policy information, including the ability to check claims statuses, view payment history, print Explanations of Benefits and proof of insurance, order a replacement ID card, make a one-time credit card payment, and more.

Register today at [gomedico.com](https://gomedico.com).

and have your policy number available. Click

**Member Login** to get started.

# Hospital Indemnity Claims

## Frequently Asked Questions



**Q. How long do I have before I need to submit my Hospital Indemnity claim?**

- A. All claims need to be submitted within 15 months of the date from which your services are received. To speed up the processing of your claim, you should file as soon as possible after services have been received.

**Q. Can I use canceled checks, payment receipts, or balance forwarded bills as my billing statement?**

- A. All provider bills must be itemized and attached to the claim form. Canceled checks, payment receipts, or balance forwarded bills are not acceptable.

**Q. If I'm unable to obtain a standardized billing statement, what information does an itemized billing statement need to include?**

- A. • ICD-CM Diagnosis Code (Reason for treatment)
- CPT and/or HCPCS Procedure Codes (Services received)
  - Dates of admission and discharge
  - Provider name and address
  - If you received hospital confinement, the number of room and board days being charged
  - If you received observation stay, the number of hours/units spent in observation

*Please note that a standardized billing statement (UB04 or HCFA) is required in Kansas and Missouri.*

**Q. Will payment be sent to me or my provider?**

- A. If you signed an "Assignment of Benefits" with the provider and you have a balance still due, we will have to pay benefits directly to the provider; otherwise, benefits will be sent to you.

**Q. My plan includes the Transportation and Lodging benefit, and my provider is submitting my Hospital Indemnity claim. How do I submit my transportation and lodging expenses?**

- A. Complete and sign section 1, 2, and 4 of the Hospital Indemnity claim form and complete and sign the Claims HIPAA Authorization for Release of Protected Health Information (PHI) form. Be sure to attach a copy of applicable receipts.

**Q. My policy includes the Lump Sum Cancer rider. What do I need to submit for it?**

- A. Complete sections 1, 2, 5, and 6 of the Hospital Indemnity Claim form and sign the Claims HIPAA Authorization for Release of Protected Health Information (PHI) form. Be sure to attach a copy of the pathology report from your physician.

**Q. Why do you need a signed Claims HIPAA Authorization for Release of Protected Health Information (PHI) form?**

- A. A signed Claims HIPAA Authorization for Release of Protected Health Information (PHI) form is required so we can contact your medical provider on your behalf if additional information is needed to process your claim.

# Hospital Indemnity Claim Form



Please refer to your policy for a list of benefits covered under your plan. Covered services vary by plan.

## Important Message

Failure to submit **ALL REQUIRED INFORMATION** may delay processing this claim. To prevent possible delays, make sure to complete the claim form and include required health care provider documentation to support the claim. Written notification will be provided if additional information is needed to process a claim.

## Section 1: Policyholder information

Policy number	Date of birth (mm/dd/yyyy)
First name	Last name
Address	City/State/Zip
Preferred phone number	Email address

## Section 2: Provider information

Family physician name	
Family physician address	
Family physician phone number	First treatment date (mm/dd/yyyy)

Please list all physicians seen in the past 3 years.

Do not include dentists, chiropractors, eye doctors, or physicians listed above.

First treatment date	Physician name	Address	City, State, Zip	Phone number

**Section 3:** Treatment details

A standard UB04/HCFA1500 bill is attached. *(If you check this box, do not complete this section.)*  
**Please note that a standardized billing statement (UB04 or HCFA) is required in Kansas and Missouri.**

- An itemized billing statement is attached that includes the following information:
- ICD-CM Diagnosis Code (Reason for treatment)
  - CPT and/or HCPCS Procedure Codes (Services received)
  - Dates of admission and discharge
  - Provider name and address
  - If I received hospital confinement, the number of room and board days being charged
  - If I received observation stay, the number of hours/units spent in observation

Provider name	Treatment start date (mm/dd/yyyy)
Reason for treatment	Treatment end date (mm/dd/yyyy)

**Section 4:** Transportation and lodging benefit

- I am not claiming a Transportation and Lodging benefit. *(If you check this box, do not complete this section.)*
- My plan includes the Transportation and Lodging benefit, and my claim includes transportation and/or lodging.

Important Transportation and Lodging benefit policy coverage reminders:

- It applies to a covered loss received 50 miles or more from residence.
- To expedite the review, a copy of the corresponding billing statement for the covered loss is required.
- The benefit will only be paid once per day regardless of whether you incur travel and lodging on the same day.

- I am claiming a Lodging benefit. *(Please submit the hotel receipt(s).)*
- I am claiming a Transportation benefit. *(Please submit the bus, airline, or other transportation receipt(s).)*
- I am claiming mileage. *(If yes, please complete the information below.)*

Date of travel	Point A (address of starting point)	Point B (address of destination)



**For your protection state law requires the following statements to appear on this form.**

**FRAUD WARNING STATEMENT**

<b>Alabama</b>	Any person who knowingly presents 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.
<b>Arkansas, Louisiana, and West Virginia</b>	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.
<b>Colorado</b>	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 or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
<b>Florida</b>	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.
<b>Kansas</b>	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.
<b>Kentucky</b>	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.
<b>Maine, Tennessee, Virginia, and Washington</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.
<b>New Mexico</b>	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.
<b>Ohio</b>	Any person who, with intent to defraud or knowing that he or she 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.
<b>Oklahoma</b>	Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
<b>Oregon</b>	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law.
<b>Pennsylvania</b>	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.
<b>Residents of All Other States</b>	<b>NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.</b>

**The furnishing of forms does not constitute an admission of liability on the part of the Company.**



American Republic Insurance Company  
 American Republic Corp Insurance Company  
 Medico Insurance Company  
 Medico Corp Life Insurance Company  
 Medico Life and Health Insurance Company

### Claims HIPAA Authorization for Release of Protected Health Information (PHI)

By completing and signing this authorization, I, or my legal representative, authorize American Enterprise Group, Inc. (the "Company") and its affiliates, employees, agents and subcontractors, to receive, use and/or disclose my PHI as described below.

Policy/certificate number	
Full name of insured	Date of birth (mm/dd/yyyy)

1. Persons/class of persons authorized to receive, use, or make disclosure of PHI: **Any licensed medical professional, hospital, clinic, or other medical-related facility, pharmacy, pharmacy benefit managers, governmental agency, or insurance company.**
2. Specific description of PHI that may be received, used, or disclosed: **All medical and health information concerning advice, care or treatment provided. This includes information on the diagnosis and treatment of alcohol, drug use, test results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes.**
3. By signing this authorization, you understand and agree:
  - a. PHI may be received, used, or disclosed for the purpose of processing claims for insurance benefits.
  - b. This authorization is voluntary, and you may refuse to sign it. You further understand if you do not sign this authorization, we may not be able to process your claim for insurance benefits, resulting in a claim denial. You understand we require this PHI to determine claim eligibility.
  - c. You are entitled to receive a copy of this signed authorization upon request.
  - d. You may revoke this authorization at any time by sending written notification to the Company at: American Enterprise Group, Inc; Attn: Claims; P.O. Box 1; Des Moines, Iowa 50306-001. The revocation will not be valid if we or another third party has taken action in reliance on this authorization.
  - e. PHI may potentially be redisclosed and no longer protected by federal privacy regulations.
  - f. This authorization will expire 24 months from the date of signature.

\_\_\_\_\_  
*Signature of individual or personal representative*

\_\_\_\_\_  
*Date (mm/dd/yyyy)*

\_\_\_\_\_  
*Printed name of individual or personal representative*

If a legal representative signed this form, describe the relationship: \_\_\_\_\_

If you are signing this authorization as a legal representative of the insured, you must provide legal documentation authorizing you to act on the insured's behalf (e.g. power of attorney, legal guardianship, personal representative, administrator, executor). By signing this authorization, you certify and attest that you are authorized to complete this due to your relationship to the insured.

\* The Company includes, but is not limited to, American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company. American Republic Insurance Company administers for American Family Mutual Insurance Company, S.I., American Family Insurance Company, Continental General Insurance Company, Central Reserve Life Insurance Company, and Provident American Life Insurance Company. Medico Insurance Company administers for Ability Insurance Company and Knights of Columbus Health and Accident Division. Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company.