



## CLAIMANT'S STATEMENT AND AUTHORIZATION

(See reverse side for Directions for Submitting a Claim)

HCC Medical Insurance Services  
 P.O. Box 863  
 Indianapolis, Indiana 46206

<b>PART A: Complete for all claims. **All Checks and Correspondence Will Be Sent To The Address Below**</b>			
Insured Name:		Claimant (Patient) Name:	
Sex:	Birthdate:	Sex:	Birthdate:
Home Telephone:	Mailing Address (include Street Address, City, State, Country, and Postal Code):		
Work Telephone:			
Fax Number:			
E-mail address:			
Plan Number:		Certificate Number:	

1. Citizenship of Claimant: \_\_\_\_\_ Home Country of Claimant: \_\_\_\_\_  
 (Country where you principally reside & receive regular mail)  
 Country Visited: \_\_\_\_\_  
(MNU may request a copy of your passport)
2. Is the Claimant: A full-time Student?  Yes  No If yes, please provide the name and address of school: \_\_\_\_\_
3. Is the Claimant: Employed?  Yes  No If yes, please provide the name and address of employer: \_\_\_\_\_
4. Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses?  Yes  No If yes, please provide the following:

Name of Company:	Address:
Policyholder:	Policy Number:
Is this group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>PART B: Complete for new claims. If you need additional space, please attach additional sheets.</b>
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1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:
  
2. When did the first symptoms of this condition begin? State the exact date, if possible:  
 (If due to an accident, please complete accident questionnaire, see Part C- DIRECTIONS)
  
3. Have you ever had or been treated for the same kind of illness or injury?  Yes  No If Yes, when?  
 Name, address and telephone number of attending physician:
  
4. Name, address and telephone number of family physician (even if not consulted):
  
5. What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers of attending physicians:



**PART C: Complete for all claims.**

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to HCC Medical Insurance Services. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	
Print Name:	Date:

Signature of Patient:	
Print Name:	Date:

**ASSIGNMENT OF BENEFITS AUTHORIZATION:** I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of Insured:	Date:
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**DIRECTIONS FOR SUBMITTING A CLAIM**

1. If this is a new claim, complete ALL PARTS of this form.
2. If this claim is a result of an accident, please visit [www.hccmis.com](http://www.hccmis.com), "Downloads" to obtain the ACCIDENT QUESTIONNAIRE, or contact our office to request the form.
3. If this is a continuing claim, complete Parts A and C only.
4. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service.
5. Mail to: **HCC Medical Insurance Services**  
**P.O. Box 863**  
**Indianapolis, Indiana 46206**
6. If you have any questions, call 1-800-605-2282. If calling from outside the US, call collect to (317) 262-2132.

**INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING:** A 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.



**AUTHORIZATION FORM FOR USE AND/OR  
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

This form authorizes the HCC Medical Insurance Services (HCCMIS) to use and/or disclose your protected health information (“PHI”) to individuals you specify. For the purpose of this form, PHI shall be considered protected health information which is individually identifiable health information received from or maintained by HCCMIS. Without a completed and signed authorization form, Federal law prohibits the HCCMIS from releasing your PHI to your spouse, parent, adult children, or other family members or close personal friends unless you are present at the time of disclosure. \*No benefits will be withheld from you if you refuse to sign this form. \*

**SECTION A: Individual authorizing use and/or disclosure.**

Insured Name: \_\_\_\_\_

Policy/Certificate Number: \_\_\_\_\_

**SECTION B: The use and/or disclosure being authorized.**

*The information to be used and/or disclosed is:*

- |   |  |
|---|--|
| <input type="checkbox"/> Claim & payment data         | <input type="checkbox"/> Eligibility and Enrollment                          |
| <input type="checkbox"/> Bills, requests for payment  | <input type="checkbox"/> Payments or coverage under the Policy / Certificate |
| <input type="checkbox"/> Other (please specify) _____ |  |

*Purpose of this use and/or disclosure:*

- At my request
- Other (please specify) \_\_\_\_\_

*Persons this information may be disclosed to:*

1. \_\_\_\_\_ Relationship to Insured \_\_\_\_\_
2. \_\_\_\_\_ Relationship to Insured \_\_\_\_\_
3. \_\_\_\_\_ Relationship to Insured \_\_\_\_\_
4. \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**SECTION C: Expiration.**

This authorization will expire (complete one):

- On \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): \_\_\_\_\_



**SECTION D: Important Information About Your Rights.**

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the HCC Medical Insurance Services in writing, but the revocation will not have any effect on any actions that HCC Medical Insurance Services took before we received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

**INDIVIDUAL'S SIGNATURE**

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize HCC Medical Insurance Services to use and/or disclose my protected health information as indicated above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the Policyholder / Certificate Holder, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Policyholder / Certificate Holder for whom this authorization applies: \_\_\_\_\_

***Note: You must provide valid and current proof of your legal relationship as a personal representative.***

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.  
A copy of this form may be used as if it were an original.**

**Please submit form to:**  
HCC Medical Insurance Services  
ATTN: Claims Department  
PO Box 863  
Indianapolis, IN 46206