



HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS:

- The Administrator will complete the Policyholder Statement section. You should complete all remaining sections and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- Please make sure that you sign the Authorization for Release of Information on the reverse side of this form.
- Have your provider of service complete the Physician or Supplier Information Section on the reverse side of this form.

- MAIL COMPLETED FORM AND
HOSPITAL BILL TO:
NEBCO / WEB-TPA
PO BOX 535007
GRAND PRAIRE, TX 75053
(800) 759-0101

CLAIM PROCESSING INFORMATION (COMPLETED BY MEMBER)

▶ MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 STREET ADDRESS: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 DAYTIME TELEPHONE NUMBER: _____
 () - _____

▶ DATE OF BIRTH: MONTH ____ DAY ____ YEAR ____ ▶ SEX: MALE FEMALE
 MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE HOSPITAL INDEMNITY BENEFITS? YES NO
 IF YES, PROVIDE INFORMATION REQUESTED BELOW:
 OTHER CARRIER'S NAME _____
 ADDRESS: _____
 TELEPHONE NUMBER: _____
 NAME OF COVERED PERSON: _____
 PLAN NUMBER: _____

▶ ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
 MO ____ DY ____ YR ____

▶ ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
 MO ____ DY ____ YR ____

SOCIAL SECURITY NUMBER: _____ / _____ / _____

▶ NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT

NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

DATES OF HOSPITAL CONFINEMENT:
 FROM _____ TO _____
 FROM _____ TO _____
 FROM _____ TO _____

NATURE OF SICKNESS OR INJURY:

PATIENT INFORMATION (COMPLETED BY MEMBER ONLY FOR DEPENDENT CLAIMS)

▶ PATIENT LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 STREET ADDRESS (IF DIFFERENT FROM MEMBER'S ADDRESS): _____
 CITY: _____ STATE: _____ ZIP CODE: _____

▶ PATIENT RELATIONSHIP TO MEMBER:
 SPOUSE CHILD STEPCHILD OTHER _____

▶ PATIENT SEX: MALE FEMALE
 ▶ DATE OF BIRTH: MONTH ____ DAY ____ YEAR ____
 ▶ SOCIAL SECURITY NUMBER: _____ / _____ / _____
 ▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD:
 MARRIED? YES NO
 EMPLOYED? YES NO
 IN THE MILITARY? YES NO
 FEDERAL EMPLOYEE? YES NO

MEMBER CERTIFICATION (COMPLETED BY MEMBER)

PLEASE NOTE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I CERTIFY THAT THE CLAIM PROCESSING AND PATIENT INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE _____ DATE _____
 (SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

POLICYHOLDER STATEMENT (COMPLETED BY ADMINISTRATOR)

▶ MEMBER'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____
 SEX: MALE FEMALE DATE OF BIRTH
 MO ____ DY ____ YR ____

▶ MEMBER'S INSURANCE EFFECTIVE DATE: MO ____ DY ____ YR ____

▶ MEMBER'S PAID TO DATE: MO ____ DY ____ YR ____

▶ CERTIFICATE HOLDER ID: _____

▶ NAME OF POLICYHOLDER: _____

▶ I HEREBY CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

▶ GROUP POLICY NUMBER: **G-29128** ▶ CANCER/ICU BENEFIT YES NO
 ▶ SURGICAL BENEFIT YES NO
 AMOUNT OF DAILY BENEFIT:
 \$ _____ ▶ (INDICATE APPLICABLE BENEFIT)
 \$1000 \$2000

▶ DOES THIS MEMBER HAVE DEPENDENTS' INSURANCE? YES NO
 IF YES, SPOUSE CHILDREN
 ▶ DEPENDENTS' INSURANCE EFFECTIVE DATE: MO ____ DY ____ YR ____
 (IF APPLICABLE)
 ▶ AMOUNT OF DAILY BENEFIT (DEPENDENT) \$ _____
 ▶ DEPENDENT'S PAID TO DATE: MO ____ DY ____ YR ____

DATE SIGNED: _____ BY: _____ (TITLE)

AUTHORIZATION FOR RELEASE OF INFORMATION (COMPLETED BY PATIENT)

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT: ILLNESS (FIRST SYMPTOM) OR
MO DY YR INJURY (ACCIDENT) OR
____/____/____ PREGNANCY (LMP)

DATE FIRST CONSULTED YOU FOR
THIS CONDITION MO DAY Y R
____/____/____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

IF YES, GIVE FIRST DATE:
MO DY YR
____/____/____

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MO DY YR MO DY YR
FROM ____/____/____ THROUGH ____/____/____

NAME OF REFERRING PHYSICIAN

IS CONDITION DUE TO PREGNANCY?

YES NO

IF YES, GIVE APPROXIMATE DATE PREGNANCY COMMENCED.
MO DY YR
____/____/____

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

FEDERAL TAX I.D. NUMBER SSN EIN

SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS

SIGNED _____ DATE _____

**PLEASE REMEMBER TO ATTACH YOUR HOSPITAL BILL TO THIS CLAIM FORM
AND MAIL TO THE ADDRESS ON THE REVERSE SIDE OF THIS FORM.**