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 mail or fax.

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

Fax: 402-496-8199

Important Message

Failure to submit <u>ALL REQUIRED INFORMATION</u> 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, 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

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** 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 numb er

Section 3: Hospitalization 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

Hospital name ____________________ Admission date (mm/dd/yyyy) ____________________

Reason for treatment ____________________ Discharge 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 and starting point)	**Point B** (address and destination)

Section 5: Lump Sum Cancer benefit rider

Please refer to your policy for a listing of specific benefits covered under your plan.

☐ I am not submitting a lump sum cancer claim

☐ My plan includes a Lump Sum Cancer benefit rider, and I am submitting a lump sum cancer claim.
(If checked, please include a copy of the pathology report with your claim form.)

Date of initial diagnosis: ____________________________

Section 6: Authorization

I understand that this information will be used by American Enterprise Group, Inc. (the "Company") for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true, and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

____________________	____________________	____________________
Name of patient	Signature of patient, authorized representative, or next of kin	Date signed (mm/dd/yyyy)

(If patient is incapacitated, parent or guardian must sign. If patient is deceased, personal representative or next of kin must sign.) **The furnishing of the form is not admission of any liability on the part of the Company.**

*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.

For your protection state law requires the following statements to appear on this form.	
FRAUD WARNING STATEMENT	
Alabama	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.
Arkansas, Louisiana, and West Virginia	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.
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 or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
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.
Kansas	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.
Kentucky	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.
Maine, Tennessee, Virginia, and Washington	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.
New Mexico	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.
Ohio	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.
Oklahoma	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.
Oregon	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.
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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Residents of All Other States	**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.**
The furnishing of forms does not constitute an admission of liability on the part of the Company.	

AmericanEnterprise GROUP INC.

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.