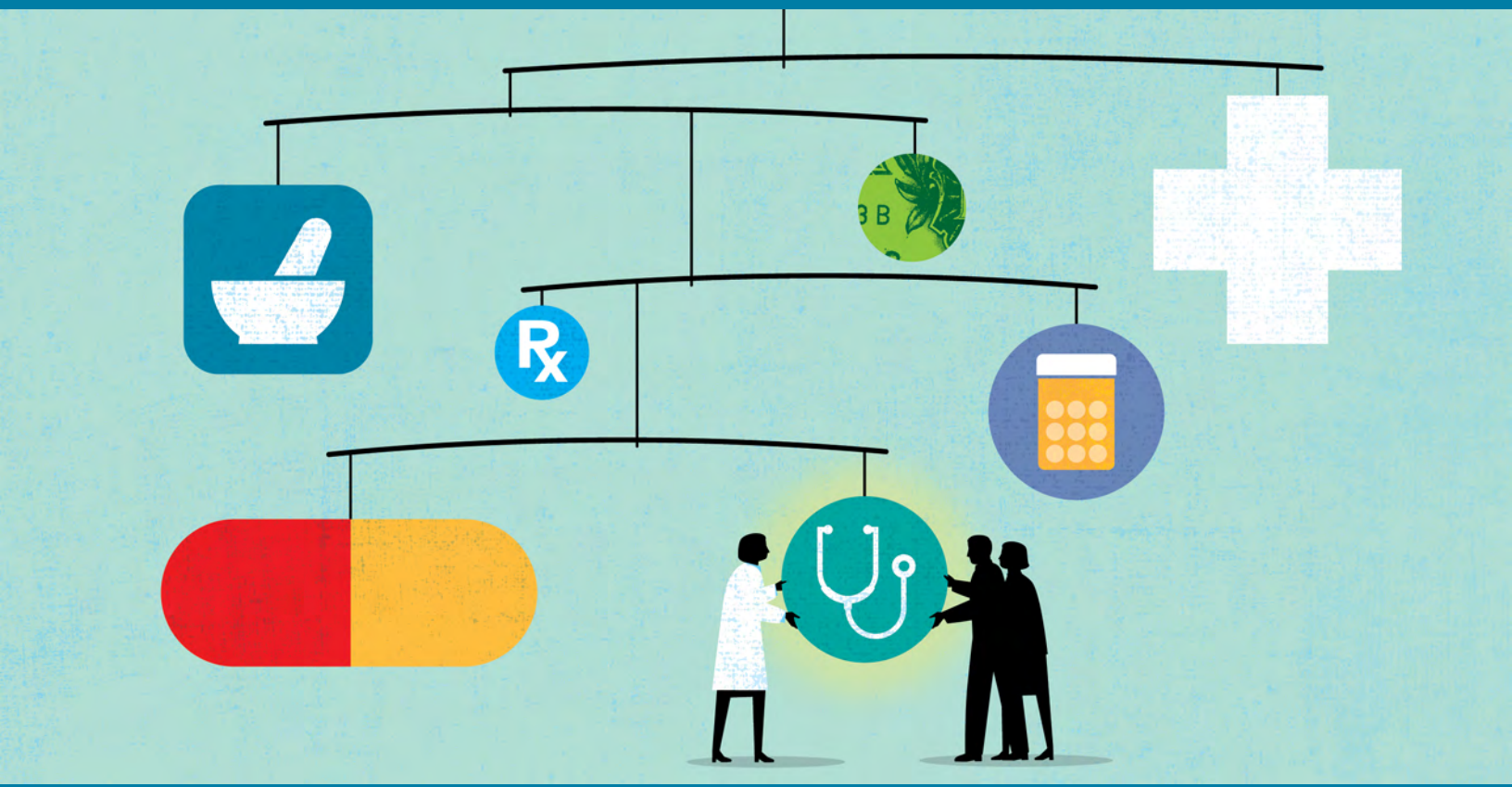
ManhattanLife™

Standing By You. Since 1850.

Home Health Care Claims Packet



HHC-CF 0525

Underwritten by:
ManhattanLife Insurance and Annuity Company
Standard Life and Casualty Insurance Company

Home Health Care and Optional Riders Claim Form

Please read the important information below:

This packet is used for filing your Home Health Care benefits and optional rider claims. Please be sure your policy number(s) is/are on all documents.

The claim form should be completed and signed by the Insured or responsible party. *Please attach Power of Attorney or Guardian papers, if applicable.*

The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, in the event we must contact your medical provider for additional information as needed.

The Physician's Health Certification form must be completed by the ordering physician.

Include any itemized statements, UB04 or Health Care Financing Administration (HCFA) forms for consideration. We *do not pay on any advanced billing*. Include any Aide note(s) for your care. Please be sure you answer ALL questions on the claim form.

An itemized statement contains:

1. The date(s) of treatment
2. The type(s) of service
3. The diagnosis
4. The medical provider's name and address

If you are only filing a claim for your Prescription Drug Benefits, please use the separate Prescription Drug Claim Form provided on the website.

Please send all information to:

ManhattanLife Claims Department
P.O. Box 924408
Houston, Texas 77292-4408

Or fax to: (713) 583-0677

Or scan for Easy Upload

NOTE: Your Policy may have a Pre-Existing Conditions Limitation and a 2-year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.

If you signed a *benefits assignment* with the provider and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.

- Processing delays may result if you do not provide all the above information.
- For your own records, we suggest you make photocopies of any information or documentation that you send or receive.

For assistance, please contact our Customer Service Department (800) 879-6542

To be completed by the insured

Policy Holder Name			Date of Birth	
Policy Number				
Address (Street)		(City)	(State)	(Zip Code)
☐ Check Box If This a New Permanent Address				
Phone		Email		

Type of benefit(s) for which the claim is being made:

☐ **Home Health Care Benefits**

- ☐ Nursing Care
- ☐ Physical Therapy
- ☐ Speech Pathology
- ☐ Occupational Therapy
- ☐ Chemotherapy Specialist
- ☐ Enterostomal Therapy
- ☐ Medical Social Services
- ☐ Respiration Therapy

☐ **Home Health Care Aide**

☐ **Home Health Care Riders:**

- ☐ Routine Annual Physical Examination*
- ☐ Home Medical Equipment*
- ☐ Accidental Death & Dismemberment*
- ☐ Ambulance Benefit*
- ☐ Accident Expense**

** Please complete the HHC - Extra Benefits Rider Claim Form, page 5*

***Please complete the HHC - Critical Accident Claim Form, page 6*

Date symptoms first appeared:_____ Date of first visit with physician? _____

Date of actual/definitive diagnosis: _____

Have you ever had this illness/condition before? ☐ Yes ☐ No If yes provide, date of previous diagnosis, name, address, and telephone number of physician that previously provided the diagnosis? _____

_____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center?_____

_____

Are you now, or have you received home health care services before? If yes, when: _____

What condition were/are you receiving care for?_____

Have you ever been diagnosed with a cognitive impairment? What diagnosis: _____ When:_____
(A cognitive impairment is classified as problems with a person's ability to think, learn, remember, use judgment and make decisions.)

Your Primary Care (family doctor) name, address, and telephone number: _____

_____

Were there any OTHER PHYSICIANS seen during the last two (2) years? *(if more space is needed, please attach separate sheet)*

If so, please provide their names, addresses and phone numbers:

Physician Name_____ Type of Doctor _____

Address and Phone Number _____

Physician Name_____ Type of Doctor _____

Address and Phone Number _____

I understand that this information will be used by ManhattanLife Insurance and Annuity Company and Standard Life and Casualty Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the questions on page 3 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 the authorization upon request.

Insured's Signature: _____ Print Name: _____ Date: _____

Physician's Health Certification

Policy Number			
Patient's Name		Patient's Address	
Date of Birth	Sex: ☐ Male ☐ Female	Physician's Tax I.D. Number	
ICD-10-CM	Principal Diagnosis		Date of Diagnosis
ICD-10-CM	Other Pertinent Diagnosis		Date of Diagnosis

Home Health Care Services Certified:

From:_____ To: _____

☐ Nursing Care (RN/LPN/LVN)	☐ Home Health Care Aide	☐ Medical Social Services
☐ Chemotherapy Specialist	☐ Respiratory Therapy	☐ Occupational Therapy
☐ Enterostomal Therapy	☐ Speech Pathology	☐ Physical Therapy

☐ Other (Specify):_____

Can the patient perform any of the following Activities of Daily Living (ADLs) without the assistance of another person?

Yes	No	
☐	☐	Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps)
☐	☐	Dressing (tying shoes, buttoning buttons or clasps)
☐	☐	Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach)
☐	☐	Toileting (maintaining adequate bathroom hygiene and toilet habits)
☐	☐	Transferring to or from bed or chair
☐	☐	Continence (the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag))

Does the patient require continuous supervision & assistance due to a Cognitive Impairment? ☐ Yes ☐ No

I certify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.

Certifying Physician's Signature _____ Date Signed _____

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation related to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

For information or to check claim status, call 1-800-879-6542.

Physician's contact information

Name: _____ Phone Number: _____

Address: _____

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ManhattanLife Insurance and Annuity Company
Standard Life and Casualty Insurance Company
ATTN: Claims Department
PO Box 924408, Houston, TX 77292-4408 Fax: 713-583-0677
For information or to check claim status, call 1-800-879-6542.

HHC – OPTIONAL RIDERS CLAIM FORM

Policyholder Information

Name of Policyholder: _____

Policy Number:_____

Date of Birth:_____ /_____ /_____ Telephone No:___ -_____ -_____

Residence Address:_____
Street *City* *State* *Zip*

☐ Check Box If This a New Permanent Address

☐ Annual Physical Examination Benefit Claim

Please provide with this form a copy of the following:

- Detailed proof of the physical exam (Itemized billing Statement, Health Care Finance Administration Form (HCFA), Uniform Billing Form (UB04), etc.)

☐ Home Medical Equipment Benefit Claim

Home Medical Equipment Category:

- ☐ Mobility Assistance
- ☐ Transfer Aids
- ☐ Bathroom Safety
- ☐ Home Accommodations
- ☐ Personal Medical Equipment

Medical Equipment – Detailed Description:

_____
_____
_____
_____
_____

Please provide with this form a copy of the following:

- Detailed proof of rental or purchased Medical Equipment and copy of physician's order. (Copy of Invoice, Itemized billing Statement, Health Care Finance Administration Form (HCFA), Uniform Billing Form (UB04), etc.)

☐ Accidental Death & Dismemberment Claim

- ☐ Death Certificate

Any Corresponding Report Available related to accident.

- ☐ Police Report
- ☐ Medical Examiner Report
- ☐ Toxicology report

Accident Information - Submit all bills related to this claim such as doctor, hospital, etc. All bills should be itemized and should include the diagnosis, services rendered, date of service and actual charges for the service.

Place of Accident:_____ Date of Accident:_____ /_____ /_____ Time of Accident:_____

Description of Accident and Nature of Injuries:_____

_____

_____

☐ Ambulance Benefits Claim

- Please provide copy of itemized billing statement.

Treating Physician Information

Physician Name:_____

Phone No:_____

Physician Address:_____
Street *City* *State* *Zip*

Policyholder Signature_____ Date Signed_____

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

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ATTN: Claims Department
PO Box 924408, Houston, TX 77292-4408 Fax: 713-583-0677
For information or to check claim status, call 1-800-879-6542.

ACCIDENT EXPENSE BENEFIT CLAIM FORM

POLICYHOLDER'S INFORMATION		
Policyholder Name (Last, first, middle initial)		Policy Number
Address (City, State, Zip Code)		☐ Check Box If This a New Permanent Address
Email Address		
Social Security Number	Date of Birth	Telephone Number

PATIENT'S INFORMATION		
Patient Name (Last, First, Middle Initial)	Social Security Number	Date of Birth
Height and Weight	Gender:	Relationship:
Date of Accident: (MM/DD/YYYYY)	Time of Accident: (Circle) AM PM	First date of treatment for injury (MM/DD/YYYYY)
Was this accident caused or contributed to by a medical condition? ☐ Yes ☐ No If yes, what is the medication condition?		
Did the accident result from the patient's occupation? ☐ Yes ☐ No If YES, please provide details.		
Provide specific details of how your accident occurred to aid the processing of your claim: Where did the accident occur?_____ Details on how the accident/injury occurred and type of injury:		
Was the patient treated by a physician or in a hospital because of this injury? ☐ Yes ☐ No (If yes, submit the UB04 itemized hospital bill or HCFA1500 itemized_physician bill)		Was this a motor vehicle accident? ☐ Yes ☐ No (If yes, please submit a copy of the police report)
Was the patient tested for alcohol and/or drugs? ☐ Yes ☐ No (If yes, please submit the blood alcohol report or drug screening)		Did the accident result in the patient's death? ☐ Yes ☐ No (If yes, please submit the certified death certificate)

I authorize any hospital, physician, or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment relative to my person, and to furnish copies of all hospital or medical records. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

The above statements are true to the best of my knowledge and belief.

_____ _____ /_____ /_____
Signature Date

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

Claim Form Addendum: Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama Any person who knowingly presents a 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. **Alaska** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Arkansas** 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. **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. **California** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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. **Delaware** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **District of Columbia** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **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. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** 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. **Kentucky** Any person who knowingly and with intent to defraud any insurance company or other person files a 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. **Louisiana** 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. **Maine** 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 or a denial of insurance benefits. **Maryland** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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. **Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **New Hampshire** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **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. **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. **Ohio** Any person who, with intent to defraud or knowing that he 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** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **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. **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. **Rhode Island** 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. **Tennessee** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **Texas** Any person who knowingly presents a 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. **Virginia** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **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 include imprisonment, fines, and denial of insurance benefits. **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.

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared by ManhattanLife Insurance and Annuity Company and Standard Life and Casualty Insurance Company for the purpose of obtaining information necessary to process a claim for benefits.

Name: _____ Policy No:_____

Date of Birth:_____

I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature regarding my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law.

I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule. I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign this copy of the authorization provided and retain a copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____

Date Authorization Signed | Signature of Claimant or Authorized Personal Representative

Mail Claims to:
P.O. Box 924408, Houston
Texas 77292-4408

Or fax to: (713) 583-0677

Scan for Claims Easy Upload

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