Hospital Indemnity Claim Filing Instructions

Underwritten by: Manhattan Life Insurance Company
Administered by: Bay Bridge Administrators LLC

Page 1 – Insured's Statement of Claim:

Must be completed each time you file a claim.
Be sure to answer every question.

Page 2 – Authorization

Claimant or Authorized Representative must sign and date Authorization on page 3 to allow physicians to release medical records to Bay Bridge Administrators, L.L.C.

Page 3 – Pre-existing Investigation Form

If claim is being filed within the first year of the policy and is for an illness, please complete this page with all physicians seen or medications taken in the past 12 months.

If provider fax numbers are known, please provide them in order to expedite this process.

Please make certain authorization on page 3 is signed and dated.

Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation by mail or fax to:
Bay Bridge Administrators, L.L.C.
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

Claim Form for **Hospital Indemnity**	**Underwritten by: Manhattan Life Insurance Company** **Administered by: Bay Bridge Administrators, LLC** **PO Box 161690** **Austin TX 78716**

INSURED'S STATEMENT OF CLAIM

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address:		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:
Employer Name:	Group Policy Number:	

Illness or Injury for which claim is being made:	Date of Accident or date Illness was first diagnosed:	Date you were first treated for your Illness or Injury:

Describe the onset and nature of your illness or the date and details of your accident:

_____

_____

_____

_____

_____

_____

Have you ever had the same or a similar condition in the past? __Yes __No Date_____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? __Yes __No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address

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.

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

_____ _____

Signature of Insured **Date**

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.

2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.

3. I authorize only designated staff of Bay Bridge Administrators, L.L.C. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, L.L.C. This revocation shall become effective on the date it is received by Bay Bridge Administrators, L.L.C. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

Signature	Print Name	Date
_____	_____	_____

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of_____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

Name of Authorized Representative:_____

Relationship to Applicant:_____ Date:_____

*A copy of the legal authority document must be on file with Bay Bridge Administrators, L.L.C.

*A copy of the legal authority document must be on file with Bay Bridge Administrators, L.L.C.
If claim is being filed during the first year of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last year:

Physician's Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____
Approximate Date Consulted: _____ Diagnosis:_____

Physician's Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____
Approximate Date Consulted: _____ Diagnosis:_____

Physician's Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____
Approximate Date Consulted: _____ Diagnosis:_____

Physician's Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____
Approximate Date Consulted:_____ Diagnosis:_____

Physician's Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____
Approximate Date Consulted: _____ Diagnosis:_____

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

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 subject to prosecution and punishment for insurance fraud.

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FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island 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 insurance company 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 and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state 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 and 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 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.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the 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 may have violated the state law.

Pennsylvania and all other states: 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.