Medical Reimbursement Form –
Claims incurred inside the United States

HTH Worldwide

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

SEE REVERSE SIDE FOR REQUIRED AUTHORIZATION SIGNATURE AND INSTRUCTIONS

PATIENT INFORMATION	INSURED INFORMATION (on ID Card)
NAME: Family Name Given Name	Certificate Number: / Group Name:
Birth Date (MM / DD / YY) / Gender ☐ M ☐ F / Relationship to Insured member ☐ Self ☐ Son ☐ Spouse ☐ Daughter	NAME: Family Name Given Name
Does The Patient Have Other Health Insurance Coverage? ☐ Yes ☐ No	Reimbursement Mailing Address:
Name of Other Health Insurance Company:	
Policy Number	Contact Phone Number: / Email Address:

TO BE COMPLETED BY THE INSURED

Please Describe your Accident or Sickness in the space provided below:

____

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____

Was this medical expense the result of a **motor vehicle accident**? ☐ Yes ☐ No

If YES, are you aware of any **pending legal action** relating to this accident? ☐ Yes ☐ No

Was this condition or injury the result of or caused by the patient's **participation in a sport**? ☐ Yes ☐ No

Was this medical expense the result of a **work related illness/injury?** ☐ Yes ☐ No

Have you been **treated for the same condition** within the last 24 months? ☐ Yes ☐ No

If yes, indicate date treatment began and date you were last treated: Began Treatment on: ________ Last Treatment Date: ________

MEDICAL INFORMATION

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

Date of Service (Mo/Day/Yr)	Provider of Service (Name of Doctor, Lab, Ambulance Company, etc.)	Service Rendered (Office Visit, X-ray, Prescription, etc.)	Illness or Diagnosis	Total (Please Indicate Currency)
			GRAND TOTAL	

PAYMENT INFORMATION

Payment Method: (check one)	☐ **Check** (payable in US$ and mailed to the address indicated above) ☐ **Pay the Provider Directly**

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

For your protection, **California** requires the following to appear on this form: 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 a state prison.

In **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.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Applicants applying for accident and health insurance in 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.

In **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.

In **Kentucky and 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.

In **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.

X ______________________________ ______________

Signature of Insured Member Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Normally, providers of health care will bill us directly for services to you and your enrolled dependents. This is the preferred procedure.

When your health care provider bills us, you do not need to send us a claim form. If a physician, ambulance company or other provider sends their bill directly to you, or you paid for the claim yourself, we have no way of knowing about your claim until we have received your bill at HTH Worldwide. This Member Claim Form was developed for you to notify us of any covered health services for which we have not already been billed.

Please read the following instructions about how to report health care services.

All bills sent must be a standard physician billing/claim form (HCFA-1500) or a standard hospital bill (UB-04 or UB-92).

Each itemized bill must include: Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), Name of patient, Date(s) of service, Amount charged for each service, Total Charge, Diagnosis and Procedure codes. Physician or Hospital statements are not acceptable.

In addition, the following information must also be included on bills for the service types listed below:

- **Registered and Licensed Vocational Nursing Services**: Hours and dates of service; Location of service (residence or name of hospital); Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)
- **Ambulance**: Pick-up and delivery points; Number of miles
- **Anesthesia**: Start Time; End Time; Surgical procedure; Surgeon Name and address
- **Prosthetic Devices, Appliances or Durable Medical Equipment**: Doctor's orders or prescriptions; Purchase price

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SEND COMPLETED CLAIM FORM TO:

HTH Worldwide
PO Box 30259
Tampa, Florida 33630
Payor ID 60054