Insured by
UNICARE Life & Health Insurance Company

Mail claims to:
HTH Worldwide Insurance
Department FC
One Radnor Corporate Center, Suite 100
Radnor, PA 19087

Administered by HTH Worldwide Insurance Services, Inc., Radnor, Pennsylvania, USA

Medical Benefits Claim Form PART A – *Please Complete - Provider Section and instructions on Reverse Side*

INSURED MEMBER INFORMATION: Insured Complete This Section

A. INSURED'S NAME (*First, M.I., Last*)

B. DATE OF BIRTH MM/DD/YYYY

C. SEX ☐ M ☐ F

D. INSURED'S MAILING ADDRESS (*Street, City, State, Zip)*

Is this a Change Of Address? ☐ Yes ☐ No

E. INSURED'S INSURANCE CERTIFICATE NO.

F. DAYTIME TELEPHONE NUMBER

G. EMAIL ADDRESS

H. MARITAL STATUS

I. ARE YOU EMPLOYED? ☐ Yes ☐ No If "Yes" Employer's Name & Address

L. WHAT WERE THE DEPATURE AND SCHEDULED RETURN DATES OF THE TRIP THE INSURED WAS ON WHEN THE ACCIDENT TOOK PLACE?

DEPARTURE DATE: MM/DD/YYYY SCHEDULED RETURN DATE: MM/DD/YYYY

PATIENT INFORMATION

A. PATIENT'S NAME (*First, M.I., Last)*

B. RELATIONSHIP TO MEMBER

C. DATE OF BIRTH MM/DD/YYYY

D. SEX ☐ M ☐ F

E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD

DEPENDENT CHILD IS:
☐ EMPLOYED FULL-TIME
☐ STUDENT FULL-TIME

NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER

ACCIDENT/ILLNESS CLAIM INFORMATION

A. DESCRIPTION OF ☐ ACCIDENT OR ☐ ILLNESS (EXACTLY HOW, WHEN, WHERE)

B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ YES ☐ NO

C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS MM/DD/YYYY

D. INJURY DUE TO AUTO ACCIDENT? ☐ YES ☐ NO

E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR DEPENDENT, FILE A CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO

F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO

G. HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS CONDITION? ☐ YES ☐ NO

IF ANSWER IS "YES", WHAT WAS THE DATE? MM/DD/YYYY

FAMILY/OTHER COVERAGE INFORMATION

A. IS SPOUSE EMPLOYED? ☐ YES ☐ NO

IF NO, HAS SPOUSE BEEN EMPLOYED DURING THE LAST 12 MONTHS? ☐ YES ☐ NO

B. NAME OF SPOUSE

C. SPOUSE'S DATE OF BIRTH MM/DD/YYYY

D. SPOUSE'S SOC. SEC./I.D. NO.

E. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER

F. IS THE PATIENT COVERD UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE? ☐ YES ☐ NO

NAME & ADDRESS

POLICY NUMBER

MEMBER'S/PATIENT'S SIGNATURE AND RELEASE: Member Must Sign All CLAIMS

A. AUTHORIZATION TO RELEASE INFORMATION – I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization that has any records, or knowledge of the health of the insured, to disclose and release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to any UNICARE Life & Health Insurance Company, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. A photostatic copy of this authorization shall be considered as effective and valid as the original. I will receive a copy of this authorization upon request. This authorization or copy shall be valid for one year from the date of signature.

PATIENT'S SIGNATURE (Parent or Guardian If Claim is for a Minor)

DATE

NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

B. PAYMENT AUTHORIZATION –

I authorize payment directly to those Health Care Providers described below, and/or as indicated on the Enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.

IF YES, MEMBER'S SIGNATURE **DATE**

C. CERTIFICATION

I certify that this information is true and correct.

MEMBER'S SIGNATURE **DATE**

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.

PART B		PHYSICIAN OR SUPPLIER INFORMATION (Please complete the form below OR attach an itemized bill.)	

Diagnosis or Nature of Illness or Injury – Relate diagnosis in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.	DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED FOR THIS CONDITION	HOSPITAL CONFINEMENT DATE FROM TO
1.			
2.	DATE ABLE TO RETURN TO WORK	TOTAL DISABILITY DATES FROM TO	PARTIAL DISABILITY DATES FROM TO
3.			
4.	NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE		

A. DATE OF SERVICE	B. PLACE OF SERVICE ❋	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (CPT-4:)	(Explain unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES	

YOUR PATIENT'S ACCOUNT NO.	**PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING.**	PHYSICIAN OR PROVIDER NAME AND ADDRESS	TOTAL CHARGE
	TAX I.D. #		AMOUNT PAID
	SOC. SEC. #	PHYSICIAN OR PROVIDER TELEPHONE/FAX NUMBER	BALANCE DUE
I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.		**PHYSICIAN'S OR PROVIDER'S SIGNATURE**	DATE

❋	1. (IH) - Inpatient Hospital	4. (H) - Patient's Home	7. (NH) - Nursing Home	O. (OL) - Other Locations
	2. (OH) - Outpatient Hospital	5. (PSY) - Day Care Facility	8. (SNF) - Skilled Nursing Facility	A. (IL) - Independent Laboratory
	3. (O) - Doctor's Office	6. (PSY) - Night Care Facility	9. Ambulance	B. Other Medical Facility

INSTRUCTIONS FOR FILING A CLAIM

The following steps will assist you in filing claims. **Please note that submitting an incomplete form will result in the delay of processing your claim.**

1. **IMPORTANT**
   - A completed claim form must be included with each submission for each member of the family for each separate accident or illness. Please answer all questions, even if the answer is "none" or "N/A".
   - You must sign and date your claim form (Insured's/Patient's Signature and Release Section)
   - If another health insurance plan is the primary payer, you must include a copy of the other plan's Explanation of Benefits (EOB) when you submit your claim form.
   - You and/or the provider of service must submit all necessary documentation needed to properly evaluate the claim. Operative reports, medical records or lab/x-ray results may be required. Fees for this documentation are the member's responsibility.
   - All claims must be filed with our office within ninety (90) days from the date of the incurred expense.
   - Claimed medical expenses from outside of the United States still need an itemized, translated bill to be submitted.

2. **ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR…**
   - Surgery, Doctor's Visits, Hospital Confinements or any other situations where reimbursement for medical expenses are being sought
   - Be certain that procedure codes and ICD-9 Diagnosis Code (Physician or Provider Section, Blocks C and D) are completed.

3. **IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:**

ALL BILLS

Insured's Name	Date of Service
Patient Name	Diagnosis
Type of service	Charge for Service

DRUG BILLS

(Please tape to an 8 ½" x 11" piece of paper)

Patient Name	Prescription Date
Physician Name	Drug Name
Prescription Number	Charge

   - Be certain to include Physician or Tax Identification Number
   - Original bills must be submitted and will not be returned to you – make copies for your records
   - Balance due statements, credit card receipts, register receipts, cancelled checks fax or photocopies are not acceptable proof of loss

4. **ADDITIONAL INFORMATION**
   - Save your Explanation of Benefits – duplicate vouchers are not available
   - Please mail the completed form and supporting documentation to:

HTH Worldwide Insurance Services, Inc.
Departments FC
One Radnor Corporate Center, Suite 100
Radnor, PA 19087
USA
Tel: (877) 865-5980 or (610) 254-8769 Fax: (610) 293-3529