Sydney ADMINISTRATORS

# HOSPITAL INDEMNITY

HOSPITAL CONFINEMENT & ADDITIONAL INDEMNITY BENEFITS INSURANCE PLAN

## CLAIM FORM

**Sydney Administrators LLC**

690 Main Street #346
Safety Harbor, FL 34695-3551


We understand that your concerns are unique, and we are here to offer you personalized assistance.


Phone: 866-578-5789
Fax: 727-440-8168


Office Hours:
Monday to Friday
9:00am to 5:00pm (EST)

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# CLAIM FORM

## HOSPITAL INDEMNITY

### NECESSARY STEPS FOR FILING YOUR HOSPITAL INDEMNITY CLAIM

Avoid unnecessary processing delays by making sure you follow all of the steps (right).

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**01** **PATIENT'S STATEMENT**

Each claim submitted should include a fully completed Patient's statement.

**02** **PHYSICIAN'S STATEMENT**

Each claim submitted should include a fully completed Physician's Statement

**03** **ITEMIZED HOSPITAL AND PHYSICIAN BILLS**

Please include a copy of all itemized hospital and physician bills that explain all procedures performed for this claim to be processed.

- Your medical provider may know them as UB04 (hospital); HCFA 1500 (physician) or physician super bill.
- This could include an Explanation of Medicare Benefits (EOMB), Explanation of Benefits (EOB), a Statement of Claim and/or a completed Physician's Statement.

**NOTE:** Your Policy has a 6-Month Pre-Existing Condition Limitation and a 2-Year Policy Contestability Period.

## WAYS TO SUBMIT A CLAIM

**MAILING ADDRESS**

Sydney Administrators LLC
690 Main Street #346
Safety Harbor, FL 34695-3551

**FAX NUMBER**

**727-440-8168**
We will respond by mail within 15 business days of receipt of your claim

**EMAIL ADDRESS**

admin@sydneytpa.com

**ONLINE UPLOAD**

Click to securely upload

# PATIENTS' STATEMENT

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**PATIENT'S CLAIM FORM**

Policy Number

| 1. Insured's Name | 2. Phone No. (please include area code) | 3. E-mail Address |
|---|---|---|
| 4. Address (Street, City, State, Zip Code) - If Address is New, Please Check Box ❑ | | |

**PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to Federal Life Insurance Company. If claim is for hospital or doctor expenses please attach itemized bills.**

| 5. Patient's Name (if other than the insured) | | 6. Birth Date (mm/dd/yyyy) |
|---|---|---|
| 7. Date patient became ill, accident occurred, or date of preventative care (mm/dd/yyyy) | 7a. If accident, how did it happen? Please explain. | |
| 8. Date patient first saw any doctor for this condition if non-preventative care? (mm/dd/yyyy) | 8a. Were you ever sick with this condition before? ❑ Yes ❑ No | 8b. If YES, when (mm/dd/yyyy) |
| 9. Doctor's Name and Address (Street, City, State, ZIP) | | |
| 10. Did you or will you file a workers compensation claim? | 10a. If YES, Employer's Name and Address (Street, City, State, ZIP) | |
| 11. If hospitalized, Name and Address of facility (Street, City, State, ZIP) | | |
| 12. If care provided by nursing home, Name and Address (Street, City, State, ZIP) | | |
| 13. Family Doctor Name and Address (Street, City, State, ZIP) | | |
| 14. Other doctors seen during the last 2 years: | | |

I understand that this information will be used by Federal Life Insurance Company for the purpose of evaluating my claim for insurance benefits. I declare 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 am entitled to receive a copy of this authorization upon request.
**BE SURE TO SIGN BELOW.**

Name of Patient

Signature of Patient's authorized representative, or next of kin | Date Signed (mm/dd/yyyy)

IF PATIENT IS DECEASED, personal representative or next of kin must sign. **The furnishing of this form is not admission of any liability on the part of Federal Life Insurance Company.**

**Provide the following for direct deposit:**

Name of bank: ______________________________ Name on account: ______________________________

Routing number: ____________________________ Account #: ____________________________________

You may also provide a copy of a blank, voided check along with your claim.

# PHYSICIAN'S STATEMENT

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### PATIENT'S INFORMATION

| | | |
|---|---|---|
| 1. Patient's Name *(First Name, Middle Int., Last Name)* | 2. Alternate Name | 3. Patient's Birth Date (mm/dd/yyyy) |
| 4. Patient's Policy Number | 5. If Preventative Care, Check Here ❑ | 6. Date of Illness *(injury, accident, first symptom or preventative care) (mm/dd/yyyy)* |
| 7. Date first consulted for this condition *(mm/dd/yyyy)* | 8. Has Patient had same or similar symptoms prior? ❑ Yes ❑ No | 9. If Patient was seen for an emergency, Check Here ❑ |
| 10. Is this injury/sickness work related? | 11. Name of referring physician or other source | 12. For services related to hospitalization, provide hospitalization dates *(mm/dd/yyyy)*<br>Admitted: __/__/____ Discharged: __/__/____ |
| 13. Name and Address of facility where services rendered *(if other than home or office)* | | 14. Was laboratory work performed outside your office? ❑ Yes ❑ No |

15. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in Column D by reference numbers 1, 2, 3, Etc. or DX Code (ICDA9)

1. 
3. 
2. 
4. 

| 16. A. Date of Service | B.* Place of Service | C. Fully describe procedures, medical services or supplies furnished for each date given Procedure Code (CPT) Identify) (Explain unusual services or circumstances) | D. Procedure Code (CPT) | E. Diagnosis Code | F. Charges | G. Days or Units | H. Type of Service** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| | | | |
|---|---|---|---|
| 17. Signature of Physician or Supplier<br><br>Signed Date | 18. Total Charge | 19. Amount Paid | 20. Balance Due |
| | 21. National Provider I.D. | 22. Physician's or Supplier's Name, Address, ZIP, & Phone No.<br><br>I.D. No. | |
| 23. Your Patient's Account No. | 24. Your Employer I.D. No. | | |

*** PLACE OF SERVICE CODES**

11 - (O) Doctor's Office
12 - (H) Insured's Home
21 - (IH) Inpatient Hospital
22 - (OH) Outpatient Hospital
31 - (SNF) Skilled Nursing Facility
32 - (NH) Nursing Home
41 - Ambulance
51 - Night Care Facility (PSY)
53 - Day Care Facility (PSY)
99 - (OL) Other Locations
A - Independent Laboratory
B - Other Medical/Surgical Facility
C - (RTC) Residential Treatment Center
D - (STF) Specialized Treatment Facility

**** TYPE OF SERVICE CODES**

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

# PHYSICIAN'S STATEMENT

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### PROVIDER'S INFORMATION

List full name, address and phone # of your Primary Care Physicians:

| Name | | Phone | | Date First Seen |
|---|---|---|---|---|
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |

List full name and address of any other medical providers who have treated you and their specialty:

| Name | | Phone | | Date First Seen |
|---|---|---|---|---|
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |
| Name | | Phone | | Date First Seen |
| Address | City | | State | ZIP |

*We ask that you make photocopies of any correspondence sent to our office to keep for your records.*

# FRAUD LANGUAGE

## HOSPITAL INDEMNITY CLAIM FORM

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**NOTE TO INSURED:**
Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. ***Thank you.***

| | | | | | | |
|---|---|---|---|---|---|---|
| Alabama | Arkansas | California | Connecticut | Georgia | Iowa | Illinois |
| Kansas | Louisiana | Massachusetts | Michigan | Missouri | Mississippi | Montana |
| North Carolina | North Dakota | Nebraska | Nevada | Puerto Rico | Rhode Island | South Carolina |
| South Dakota | Texas | Utah | Vermont | Wisconsin | West Virginia | Wyoming |

**GENERIC FRAUD WARNING** *(to be used for above states only)*
Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

**ALASKA, DELAWARE, IDAHO, INDIANA, OKLAHOMA**
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.

**COLORADO, WASHINGTON D.C., HAWAII, MAINE, TENNESSEE, 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 may include imprisonment, fines or a denial of insurance coverage.

**ARIZONA, MINNESOTA, NEW JERSEY, NEW MEXICO**
Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

**KENTUCKY, OHIO, OREGON**
Any person who intends to defraud or knowingly assists in committing a fraud against an insurer by submitting an application or claim containing a false or deceptive statement is guilty of insurance fraud.

**FLORIDA**
Any person who, knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section 817.234 F.S.

**MARYLAND**
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

**PENNSYLVANIA**
Any person who knowingly and with intent to defraud any insurance company or other person files 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.

**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.

**WASHINGTON STATE**
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.

Sydney

# NOTES

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