CareAmerica
Life Insurance Company

Care America Insurance Company
PO Box 1812
Beattyville, KY 41311
Tel: 1-866-510-8779

# SHORT TERM HEALTH INSURANCE CLAIM FORM

1. ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY
2. ATTACH ITEMIZED BILLS OR PRESCRIPTION RECEIPTS
3. SIGN THE AUTHORIZATION BELOW
4. SEND THE COMPLETED FORM DIRECTLY TO CAREAMERICA INSURANCE COMPANY AT THE ADDRESS SHOWN ABOVE

**IMPORTANT NOTICE: 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.**

**1**

| NAME OF THE INSURED | PHONE NO. | SOCIAL SECURITY NUMBER — — | POLICY NUMBER |
|---|---|---|---|
| MAIL ADDRESS — STREET | CITY | STATE | ZIP |
| NAME OF PATIENT | | BIRTH DATE (Mo.-Day-Yr.) — — | RELATIONSHIP |

**2**

Have you, your spouse or covered children been insured under another health plan during the twelve months prior to the effective date of this policy?

❑ YES ❑ NO If "Yes", complete the following:

(IF THERE WAS MORE THAN ONE INSURANCE CARRIER, PLEASE ATTACH A SEPARATE PAGE WITH THE FOLLOWING INFORMATION ABOUT EACH PLAN.)

| POLICYHOLDER NAME | POLICY OR ID # | GROUP NUMBER | EFFECTIVE / TERM DATES |
|---|---|---|---|
| NAME OF INSURANCE COMPANY | ADDRESS OF CLAIMS OFFICE | | PHONE # OF CLAIMS OFFICE |
| EMPLOYER OR GOVERNMENT SERVICE NAME | EMPLOYER OR GOVERNMENT SERVICE ADDRESS | | PHONE # |

**3**

1. Describe condition responsible for expenses **(if injury, provide details of injury, including date.)**

2. Expenses were the result of: ❑ Injury ❑ Pregnancy ❑ Illness — Date treatment first occurred — DATE (Mo., Day, Yr.)

3. Date symptoms were first noticed — DATE (Mo., Day, Yr.)

4. PHYSICIAN'S NAME

PHYSICIAN'S COMPLETE ADDRESS AND PHONE #

5. Please sign this assignment of benefits if you wish payment to be made to any of the health care providers listed below:
I authorize payment of benefits to the provider(s) of services indicated below:

**INSURED OR AUTHORIZED PERSON** _____ **DATE** _____

LIST BELOW ALL PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SEEN FOR THIS CONDITION:

| NAME | ADDRESS | PHONE NO. | DATES SEEN | ASSIGNMENT? YES | NO |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PLEASE SIGN THIS ASSIGNMENT OF BENEFITS IF YOU WISH PAYMENT TO BE MADE TO THE PHYSICIAN ON THE REVERSE SIDE OR LISTED ABOVE.**

I authorize payment of medical benefits to the Provider of Services specified.

X _____
(Insured or Authorized Person)

## AUTHORIZATION TO OBTAIN INFORMATION

**4**

I authorize these persons having any records or knowledge of me or my health: physician, medical or health care provider, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, employer or plan administrator, government agency, organization or entity administering a benefit program, educational, vocational or rehabilitation organization or program, to give this information: all medical information on me, including medical history, diagnosis, prognosis and treatment of any physical or mental condition, to CareAmerica Insurance Company. I understand that CareAmerica will use the information to determine my eligibility or entitlement for insurance benefits. I understand I have right of access and correction with respect to all personal information provided under this authorization. CareAmerica may release information about me to a reinsurer, a plan administrator, or any person performing business or legal services for CareAmerica in connection with my claim. I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with CareAmerica Insurance Company. A photocopy of this authorization is as valid as the original.

Insured/Patient _____ (Print Name) X _____ (Patient Signature (or parent, if minor)) Date _____