ACCIDENTAL INJURY CLAIM FORM FILING INSTRUCTIONS

PLEASE SUBMIT THE FOLLOWING WITH YOUR COMPLETED AND SIGNED ACCIDENTAL INJURY CLAIM FORM (Sections A through F):

PLEASE SUBMIT THESE ITEMS ONE TIME PER ACCIDENT. ANY ADDITIONAL CLAIMS SUBMITTED FOR THIS SAME ACCIDENT SHOULD REFERENCE THE ACCIDENT DATE SHOWN ON THIS CLAIM FORM.

- ☐ Accidental injury claim form (see Sections A – F on the enclosed form) – signed
- ☐ Authorization to obtain medical/confidential information (see enclosed form) – signed
- ☐ Automobile accident – Police report
- ☐ Physician statement – Section G
- ☐ Physician and medical facility information
- ☐ Certified death certificate, if applicable
- ☐ Itemized medical bills for your treatment which include the following required information:
  - ☐ Patient information
  - ☐ Date of service
  - ☐ Charge amount
  - ☐ CPT code or procedure description
  - ☐ ICD code or diagnosis for treatment

Please note: Medicare statements and Explanation of Benefits (EOB) from other insurance companies cannot solely be used to process claims.

WHERE TO SUBMIT CLAIMS:

Mail: Claims Department
PO Box 31374
Salt Lake City, UT 84131-0374

Fax: 1-801-478-7581

Insured Name:
Policy No.:

SECTION A: POLICYHOLDER INFORMATION (please print)

Policy identification number		
Last name	First name	Middle initial
Date of birth	Physical address (residence)	
City	State	ZIP Code
Contact phone number	May we leave message? ☐ Yes ☐ No	Email
Employer's name	Occupation and title	
Work address	Insurance through employer? ☐ Yes ☐ No	Work phone number

SECTION B: PATIENT ADDRESS INFORMATION
(if different from Policyholder)

Last name	First name	Middle initial
Contact phone number	Date of birth	
Physical address (residence)		
City	State	ZIP Code

SECTION C: PATIENT INFORMATION

Gender: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married ☐ Other	Relationship to primary insured: ☐ Self ☐ Spouse ☐ Dependent child	Check if disabled ☐ Self ☐ Spouse ☐ Dependent child [name_____] ☐ Dependent child [name_____]
Employer's name	Occupation and title		Work phone number
Work address _____ _____ _____ _____ _____	Medical insurance through employer? ☐ Yes ☐ No If yes, name and policy identification number of insurance _____ _____ _____ _____		

Insured Name:
Policy No.:

SECTION D: ACCIDENT and OTHER INSURANCE INFORMATION

Your policy document provides the definition of an accident for reference in completing this section.

1. Is this claim related to an accident or injury? ☐ Yes ☐ No; If no, please sign, date, and return.

2. Is this accident motor vehicle related? ☐ Yes ☐ No

3. Where did this accident occur? ☐ On job ☐ Off job: indicate where _____

4. Place of accident or injury: _____
_____

5. Date of accident __/__/____ Time of day: __:__ AM / PM (circle one)

6. Do **you** have other insurance, **besides medical, that may pay for your accident-related medical expenses?**
☐ Yes ☐ No; If yes, please provide name, address, phone number, and policy identification number.
_____
_____
_____
_____

7. On the date of the accident did you have **medical insurance** coverage?
☐ Yes ☐ No; If yes, please provide name, address, phone number, and policy identification number.
_____
_____
_____
_____

8. Have you previously been treated for the same or similar condition?
☐ Yes ☐ No; If yes, please list dates previously seen, doctor and hospital names for this similar condition.
_____
_____
_____
_____

9. Please provide a thorough description of the **accident** that caused your injury. (Attach additional pages, if needed.)
_____
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SECTION D: ACCIDENT and OTHER INSURANCE INFORMATION (continued)

10. Please describe the physical **injury** caused by the accident. (Attach additional pages, if needed.)

11. Do you have a lawyer for this accident?
☐ Yes ☐ No; If yes, please list name and address of your lawyer.

Insured Name:
Policy No.:

SECTION E: HEALTHCARE PROVIDER AND MEDICAL FACILITY INFORMATION

Where claimant received treatment

Treating physician or other healthcare provider name	Phone number	Fax number
Address		
City	State	ZIP Code
Email		

Primary physician name (if different than above)	Phone number	Fax number (if available)
Address		
City	State	ZIP Code
Email		

Hospital or other facility name (if applicable)	Phone number	Fax number (if available)
Address		
City	State	ZIP Code
Email		

Rehabilitation facility (if applicable)	Phone number	Fax number (if available)
Address		
City	State	ZIP Code
Email		

Insured Name:
Policy No.:

SECTION F: PATIENT SIGNATURE SECTION

Please be sure to include the following information with this claim form:

☐ **Itemized bills from a physician and/or facility including diagnosis and procedure codes and charge amounts (Itemized bills may include but are not limited to the following claim forms: UB04, CMS-1500)**

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form.

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony. Please see the attached Fraud Warning Statements (Section H) for any state variations.

_____	_____	___ /___ /_____
Patient signature (or legal representative)	Relationship to policyholder	Date

SECTION G: PHYSICIAN OR OTHER HEALTHCARE PROVIDER STATEMENT

To be completed and signed by the physician or healthcare provider

Please answer each question COMPLETELY. Failure to complete all sections may delay processing of this claim.

Policy identification number USE LABEL FROM POLICY IDENTIFICATION CARD	Policyholder name USE LABEL FROM POLICY IDENTIFICATION CARD	
Patient name	Patient date of birth	
Physician name	Phone number	Fax number

Mailing address

City	State	ZIP Code

Where did this accident occur? ☐ Home ☐ Work ☐ Other: _____ Date of accident: ___/____/_____

Please describe how this accident occurred.

To your knowledge, has this patient ever had the same or a similar medical condition?
☐ Yes ☐ No; If yes, please describe (including date):

Date of service	Diagnosis/ICD code	Surgery/CPT code	Description of surgery	Charges

Was patient hospitalized as result of the diagnosis? ☐ Yes ☐ No ➤ If yes, was patient kept overnight? ☐ Yes ☐ No	Confinement dates	Discharge date
Hospital name	City	State

Was patient confined to ICU? ☐ Yes ☐ No ➤ Level of care provided _____	Confinement dates

Is patient's past medical history on file in your office? ☐ Yes ☐ No; If yes, years available: _____

_____ ___ /___ /_____ _____
Physician signature Date Tax ID number

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SECTION H: FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA, DELAWARE, FLORIDA, IDAHO: Your state requires us to notify you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, 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.

ARIZONA, KENTUCKY, OHIO: WARNING: 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 guilty of insurance fraud.

CALIFORNIA: For your protection California law requires the following warning statement 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 state prison.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

INDIANA, MINNESOTA: Your state requires us to notify you that: any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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: Your state requires us to notify you that: any person, 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 under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

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.

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.

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Insured Name:
Policy No.:

Authorization to obtain medical/confidential information

Conforms to HIPAA Privacy Rule

1. Claimant information—the individual for whom the claim is being filed			
Printed name		Date of birth	
Address	City	State	ZIP

2. Disclosing party—parties authorized to release information about me

Any physician or other healthcare provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

4. Purpose of authorization—how my information will be used

To administer benefits under a policyholder's insurance.

5. Duration of authorization

Twelve (12) months from the date written below, unless I specify an earlier date here:

6. Receiving parties—parties authorized to receive information about me

On behalf of Golden Rule and UnitedHealthcare and affiliated entities.

7. Important information—review carefully before signing

- Refusing to sign this authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service Department, PO Box 31374, Salt Lake City, UT 84131-0374.
- The receiving parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

8. Approval—must be signed and dated by me or my legal representative* to be valid

Print name: _____Relationship: _____

Signature: _____ Date: _____

* Legal representatives need to provide documentation of legal authority

Claims Department, PO Box 31374, Salt Lake City, UT 84131-0374
Phone: (800) 657-8205 Fax: (801) 478-7581