# HOSPITAL INDEMNITY CLAIM FORM

**INSTRUCTIONS** **For Customer Service, call 1-866-317-0167 (toll-free)**

1. Answer every question within PART A – EMPLOYEE'S STATEMENT.
2. Sign PART A – EMPLOYEE'S STATEMENT under AUTHORIZATION TO RELEASE INFORMATION.
3. Attach all bills, including hospital bills, for charges that you refer to on this claim form. These bills must identify the patient's name, conditions treated (diagnosis), type of treatment, date each expense was incurred, and itemized charges.
4. Mail this form and the attached bills to: **America's Choice Healthplans, LLC**
   **13111 NW Freeway, Suite 510**
   **Houston, TX 77040**

| **PART A - EMPLOYEE'S STATEMENT** | | | | **Employer's Name:** Conroe Independent School District |
|---|---|---|---|---|
| **FULLY COMPLETE FOR ALL CLAIMS** | Employee's Name (Please Print) | Group Number<br>**71200** | Date of Birth | Social Security Number |
| | Address: Street and No. | City | State | Zip Code |
| | Phone Number | This claim is on: ☑ Myself | Are you covered under another plan? ❑ Yes ❑ No | |
| | What was the sickness or injury? | | On what date did it begin? | Date of first expense for this condition: |
| | Are Benefits payable from any other source (including Military, Automobile, Liability Insurance, School Accident Insurance) for the expense submitted?<br>❑ Yes ❑ No | If "Yes", (a) Other Source:______<br>(b) Address:______<br>(c) Policy No. or I.D. No.______ | | |

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct and that it is unlawful to fill out this form with information that I know is false or to leave out facts I know are important. This authorization or photo static copy of the original shall be valid for one year from the date of signature. I understand that I may request to receive a copy of this authorization.

➢______________________________ ______________
Employee/Patient Date

### AUTHORIZATION TO PAY PROVIDER

I authorize payment of all medical benefits for services rendered from those physicians or providers described below and/or as indicated on the enclosed bills. I understand that I am financially responsible to the provider(s) for charges not covered by the authorization.

➢______________________________
Employee's Signature Date

### AUTHORIZATION TO PAY PLAN PARTICIPANT

Please sign below for payment to go directly to Covered person.

➢______________________________
Employee's Signature Date