# *Medical Expense Claim Form*

Claims Department: 67 Main Street, PO Box 5670, Cortland, NY 13045
Phone No: 1-800-822-3747 | Fax: 607-756-5967 | Email: loss_notice@mcneilandcompany.com

## *Medical Expense Claim Instructions*

Your policy provides excess medical insurance coverage providing benefits in excess of the benefits provided under your primary medical insurance policy. A Medicare Supplement policy would be considered a primary insurance policy. As such, you must first file your claim with your primary medical insurance company. If you are not fully reimbursed by your primary insurance company, you may file a claim for the unpaid medical expenses as noted in these instructions.

Please complete and sign the Medical Expense claim form in full and return it with the documentation noted below.

For all claims, submit:

- Copies of invoices or receipts for all claimed medical expenses. Invoices should show the date of service; the office or facility where the service was provided; the condition treated and the nature of the treatment received.
- Proof of payment of the claimed medical expenses – copies of both sides of checks, copies of credit card statements or receipts for cash payments;
- Proof of loss:
    - An attending Physician's Statement completed by the patient's primary treating physician;
    - Medical records or other documentation showing the nature of the condition and the treatment received;
    - Copies of Explanations of Benefits from your primary insurance company showing any claims paid or denied

**Your claim should be submitted to the address at the top of these instructions.**

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## Section 1 - Claiming Benefits

### *To be Completed by Insured Claiming Benefits*

| | | |
|---|---|---|
| Name of Claimant / Insured | Certificate/Policy Number | Phone Number ( ) |
| Address | | Male ☐ Female ☐ |
| | | Date of Birth |
| Email Address | | Date Incident Occurred |

Do you have other medical insurance that may provide coverage for this claim? Yes ☐ No ☐

If so, has a claim been submitted to the other company? Yes ☐ No ☐

Name address and phone number of the other insurance company

| | |
|---|---|
| Primary Insurance Carrier | Policy Number. |
| Secondary Insurance Carrier | Policy Number. |
| Date injury occurred or symptoms began | Date first treated for this illness or injury |
| Explain when and where injury occurred or illness began | Describe nature and diagnosis of illness or injury |

Name, address and phone number of physician who first treated you for this condition

If hospitalized, name and address of the hospital

Was an accident or police report filed? Yes ☐ No ☐ If yes, please provide a copy.

Had you ever been treated for this condition before? Yes ☐ No ☐ If so, when?

Name, address and phone number of physician who previously treated this condition:

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## Section 2 - Claimed Expenses

Please list all medical expenses incurred as a result of this sickness or injury. Enclose copies of medical bills, reports and explanations of benefits from your Primary and Supplemental insurance companies.

### *Claimed Expenses*

| Name of Provider | Date of Service | Type of Service | Amount of Bill | Amount paid by other Insurance | Amount Claimed |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | **Totals** | | | |

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

**Signature of Claimant** **Date**

## Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release any information requested regarding this claim and the loss reported.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

_____ _____

**Patient's or Authorized Representative's Signature** **Date**

_____

**If Authorized Representative, Relationship to Patient**

_____

**or Legal Designation**

# *Attending Physician's Statement*

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## *Section 1: To be completed by claimant/insured*

### *About the Claimant*

| Name of Claimant/Insured | | | Policy Number |
|---|---|---|---|
| Address (street, city, state, zip) | | | |
| Gender Male ☐ Female ☐ | Date of Birth | Trip Departure Date | Policy Purchase Date |

### *About the Patient - Complete only if different from Insured*

| Name of Patient | |
|---|---|
| Was patient traveling with insured? Yes ☐ No ☐ | Relationship of Patient to Insured |

## *Section 2: To be completed by physician*

### *About the Diagnosis and Treatment*

| Diagnosis / ICD-9 Code (primary diagnosis) | |
|---|---|
| Diagnosis / ICD-9 Code (secondary diagnosis) | |
| Date symptoms first appeared | Date patient first consulted you for this condition |
| Has the patient ever had this condition before? Yes ☐ No ☐ | If yes, when? |
| Is this condition an exacerbation or a complication of an existing condition? Yes ☐ No ☐ | If yes, what was that condition? |
| If the patient was referred **from** another physician, name and phone number of that physician | |
| If the patient was referred **to** another physician, name and phone number of that physician | |
| Dates of medical visits as they relate to the condition causing the trip cancellation/interruption. | |
| Date of consultation _____ _____ _____ | Describe Condition/Treatment _____ _____ _____ |
| Has the patient been hospitalized for this condition or related conditions in the past 12 months? Yes ☐ No ☐ | If yes, date of admittance and date of discharge? |

### *About the Medical Condition as it relates to Travel*

| Was the Insured/Traveler unable to travel on the policy purchase date listed in Section 1 above? Yes ☐ No ☐ | |
|---|---|
| If the patient was Traveler, did you advise patient to cancel or interrupt the trip due to the medical condition? Yes ☐ No ☐ | |
| If yes, please explain:<br><br>Date you advised patient to cancel trip: | If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip? |

## *Attending Physician's Statement*

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## *Section 2, continued: To be completed by physician*

### *About the Medical Condition as it relates to Travel, continued*

| | |
|---|---|
| If the patient was non-traveler, did you advise the Traveler to cancel or interrupt the trip due to the non-traveler's medical condition? Yes ☐ No ☐ | |
| If yes, please explain:<br><br>Date you advised Traveler to cancel trip: | If no, on what date was it reasonable for the patient/insured to cancel/interrupt their trip? |
| If the condition was related to pregnancy, when was the pregnancy first diagnosed? | If related to pregnancy, expected delivery date |
| Was the patient hospitalized while traveling? Yes ☐ No ☐ | Was this an emergency room admission? Yes ☐ No ☐ |
| Name & Location of Hospital | |
| Date Admitted | Date Discharged |

### *Physician Information and Signature*

Please note: All of the above requested information is necessary for the processing of the Claimant/ Insured's claim. Any omitted items will delay processing.

Please attach copies of the patient's office records for the 6 months prior to the trip departure date.

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 may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

| | |
|---|---|
| Physician's Signature<br><br>Date | |
| Physician's Name | |
| License Number | Specialty |
| Phone Number | Fax Number |

## APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA APPLICANTS: 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.

NOTICE TO ALASKA APPLICANTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: 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.

NOTICE TO CALIFORNIA APPLICANTS: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DELAWARE APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A 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.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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 benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW HAMPSHIRE APPLICANTS: 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 in- formation is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

## APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO RHODE ISLAND APPLICANTS: 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.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO TEXAS APPLICANTS: 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.

NOTICE TO UTAH APPLICANTS: Workers' Compensation Claims Only: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO VIRGINIA APPLICANTS: 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.

NOTICE TO WASHINGTON APPLICANTS: 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.

NOTICE TO WEST VIRGINIA APPLICANTS: 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.