HCC Medical Insurance Services, LLC
Box No. 2005
Farmington Hills, MI 48333-2005
1-800-605-2282 / 317-262-2132

Claimant's Statement and Authorization Form

PART A: Complete for all claims.

** HCCMIS will update your mailing address on file to be the address below. **

Insured Name:	Sex: __ M __ F	Birth date: ___Day ___Month ____Year	
Claimant / Patient Name (if different):	Sex: __ M __ F	Birth date: ___Day ___Month ____Year	
Street Address:			
City:	State:	Country:	Postal Code:
Telephone:	E-mail address:		
Plan / Group Number:	Certificate / ID Number:		
Citizenship of Claimant:	Home Country of Claimant:		

1. Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses? __Yes __ No If *Yes*, please provide the following:	
Name of Company:	Address:
Policyholder:	Policy Number:
Is this insurance group insurance? __ Yes __ No	

2. Did you personally pay for this treatment? __Yes __No __ Bills have not been paid		
If *No*, please provide the name and details to whom any benefit should be paid and sign to indicate authorization for us to reimburse this person.		
Name:	Complete Address:	
Signature of Patient:	Print Name:	Date:
If *Bills have not been paid*, please sign to indicate authorization for us to pay the provider directly.		
I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.		
Signature of Patient:	Print Name:	Date:

PART B: Complete for new claims. If you need additional space, please attach additional sheets.

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:
2. When did the first symptoms of this condition begin? State the exact date, if possible: _____ (If due to an accident, please complete accident questionnaire. Visit www.hccmis.com, "Downloads" to obtain form.

3. Have you ever had or been treated for the same kind of illness or injury? __ Yes __ No If Yes, when? _____ Please provide attending physician information.		
Physician Name:	Address:	Telephone:

4. Name, address and telephone number of family physician (even if not consulted):		
Physician Name:	Address:	Telephone:

5. What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers of attending physicians:

PART C: Complete for all claims.

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to HCC Medical Insurance Services. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	Print Name:	Date:

Signature of Patient (if different):	Print Name:	Date:

TO SUBMIT YOUR CLAIM: Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service. If you have any questions, call 1-866-500-8060. If calling from outside the US, call collect to 317-221-8080.

Mail to: **HCC Medical Insurance Services, Box No. 2005, Farmington Hills, MI 48333-2005**

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.

HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form authorizes the HCC Medical Insurance Services (HCCMIS) to use and/or disclose your protected health information ("PHI") to individuals you specify. For the purpose of this form, PHI shall be considered protected health information which is individually identifiable health information received from or maintained by HCCMIS. Without a completed and signed authorization form, Federal law prohibits the HCCMIS from releasing your PHI to your spouse, parent, adult children, or other family members or close personal friends unless you are present at the time of disclosure. *No benefits will be withheld from you if you refuse to sign this form. *

SECTION A: Individual authorizing use and/or disclosure.

Insured Name: _____

Policy/Certificate Number: _____

SECTION B: The use and/or disclosure being authorized.

The information to be used and/or disclosed is:

___ Claim & payment data
___ Bills, requests for payment
___ Eligibility and Enrollment
___ Payments or coverage under the Policy / Certificate
___ Other (please specify) _____

_____

Purpose of this use and/or disclosure:

____ At my request
____ Other (please specify) _____

Persons this information may be disclosed to:

1. _____ Relationship to Insured _____
2. _____ Relationship to Insured _____
3. _____ Relationship to Insured _____
4. _____ Relationship to Insured _____

SECTION C: Expiration.

This authorization will expire (complete one):

____ On _____/_____/_____ (month/day/year)
____ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

_____

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SECTION D: Important Information About Your Rights.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the HCC Medical Insurance Services in writing, but the revocation will not have any effect on any actions that HCC Medical Insurance Services took before we received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability Accountability Act of 1996 (also known as HIPAA).

INDIVIDUAL'S SIGNATURE

I, having had the full opportunity to read and consider the contents of this authorization, hereby authorize HCC Medical Insurance Services to use and/or disclose my protected health information as indicated above.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the Policyholder / Certificate Holder, complete the following:

Personal Representative's Name: _____

Relationship to Policyholder / Certificate Holder for whom this authorization applies: _____

_____

Note: You must provide valid and current proof of your legal relationship as a personal representative.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
A copy of this form may be used as if it were an original.

Please submit form to:
HCC Medical Insurance Services
ATTN: Claims Department
PO Box 863
Indianapolis, IN 46206