MEDICAL CLAIM FORM

PART A – INSTRUCTIONS

1. **READ AND COMPLETE BOTH SIDES OF THIS FORM. PLEASE PRINT CLEARLY.**
2. Remember to provide either your Social Security Number or your Personal Identification Number.
3. **ATTACH A COPY OF UB-04 FORM FROM YOUR HOSPITAL OR HCFA-1500 FROM YOUR PROVIDER. THESE FORMS ARE STANDARD BILLING FORMS UTILIZED BY HEALTHCARE FACILTIES AND PROVIDERS. IF YOU CANNOT OBTAIN A COPY OF THESE FORMS, PLEASE ATTACH ALL ORIGINAL ITEMIZED BILLS OR INFORMATION RELATED TO YOUR CLAIM, INCLUDING (*Note:* *Itemized bills are **NOT*** Balance Due Statements or Explanation of Benefits.):**
   - Doctor's Name and Address
   - Doctor's Tax Identification Number
   - Patient Name
   - Diagnosis Code ICD-10
   - Date of Service
   - Charges/Cost of each treatment
   - Procedure Codes CPT
   - Place of Service Code
4. Be sure to **SIGN PART E** if you want benefits paid to your provider.
5. **MAKE A COPY OF THIS FORM** for your records.
6. Please mail or email this claim form and any documentation related to your claim to:

   ASRM, LLC
   Attention – CLAIMS' DEPARTMENT
   505 South Lenola Road, Suite 231
   Moorestown, NJ 08057
   iees@asrmllc.com

7. **Incomplete forms and the absence of itemized invoices may delay the processing of your claim.**
8. **Please call ASRM's Claims' Department at 1-800-359-7475 if you have any questions about this Medical Claim Form.**

PART B – INSURED INFORMATION

INSURED NAME (LAST, first, middle)	**GENDER**	**DATE OF BIRTH (MM/DD/YY)**	**SSN or PIN**

STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

PHONE NUMBER	**GROUP NUMBER (obtained from ID Card)**	**RELATIONSHIP TO PATIENT**

DOES THE INSURED/PATIENT HAVE OTHER HEALTH BENEFIT COVERAGE? ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE INSURANCE PLAN NAME OR PROGRAM NAME AND THE POLICY OR GROUP NUMBER.

PART C – PATIENT INFORMATION

PATIENT NAME (LAST, first, middle)	**PATIENT DATE OF BIRTH (MM/DD/YY)**	**PATIENT SSN or PIN**

GENDER	**IF PATIENT IS YOUR DEPENDENT CHILD AND OVER 25, IS HE OR SHE HANDICAPPED?** ☐ **YES** ☐ **NO**

PART D – CLAIM INFORMATION

IS THE CLAIM FOR AN: ☐ **ACCIDENT** ☐ **ILLNESS**	**WHEN DID THE ACCIDENT OR ILLNESS OCCUR? (MM/DD/YY)**

IS YOUR CLAIM THE RESULT OF PARTICIPATING IN AN INTERSCHOLASTIC OR INTERCOLLEGIATE SPORT? ☐ **YES** ☐ **NO**

IS YOUR CLAIM THE RESULT OF AN OCCUPATIONAL ACCIDENT OR ILLNESS? ☐ **YES** ☐ **NO**

PLEASE EXPLAIN WHAT YOU WERE TREATED FOR AND, IF TREATMENT WAS THE RESULT OF AN ACCIDENT, PROVIDE DETAILS OF WHEN, WHERE AND HOW THE ACCIDENT HAPPENED. (If you need additional space, attach a sheet of paper to this form.)

PART E – ASSIGNMENT OF BENEFITS

TO BE COMPLETED BY THE INSURED. DO NOT SIGN THIS SECTION IF FEES HAVE ALREADY BEEN PAID TO YOUR PROVIDER.
I APPROVE THE PAYMENT OF BENEFITS TO THE DOCTOR OR OTHER PROVIDER SHOWN ON THE ITEMIZED BILL (Tax Identification Number must be included). I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNED	**DATE (MM/DD/YY)**	**RELATIONSHIP TO THE PATIENT**

PART F – AUTHORIZATION

IF THE PATIENT IS A MINOR OR IS UNABLE TO SIGN, THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.

To all physicians, hospitals, service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, self-insured and pre-paid health plans):

You are authorized to permit SiriusPoint America Insurance Company and its authorized representatives, to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition, including information relating to mental illness, drug or alcohol treatment, HIV (AIDS Virus), and disease of the Patient identified in Part C of this form.

I understand the information obtained will only be used by SiriusPoint America Insurance Company and its authorized representatives to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau, and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. I further understand that such persons and organizations to whom disclosure is made may not be required by Federal privacy laws (such as the HIPAA Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing such persons and organizations. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to SiriusPoint America Insurance Company or its authorized representatives, but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

SIGNED	DATE (MM/DD/YY)	RELATIONSHIP TO THE PATIENT

IF SIGNED BY OTHER THAN THE PATIENT, PLEASE PRINT NAME & ADDRESS AND INCLUDE GUARDIANSHIP PAPERS OR OTHER EVIDENCE OF LEGAL REPRESENTATION

PART G – FRAUD NOTICE AND ACKNOWLEDGEMENT

I certify to the best of my knowledge that all statements and answers in this claim form are true and complete. I understand that any person who, knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

SIGNED	DATE (MM/DD/YY)	RELATIONSHIP TO THE PATIENT

The laws of some states require us to furnish you with the following notice:

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: 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.

Arizona: 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.

Arkansas, Louisiana, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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: 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.

Delaware: 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.

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.

Florida: 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

Kentucky: 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.

Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: 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.

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

New Hampshire: 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 as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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.

New York: 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 $5,000 and the stated value of the claim for each violation.

Ohio: 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.

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.

Pennsylvania: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.