CAREGIVER SHIELD
Short-Term Home Health Care Claim Form and Riders

Please read the important information below:

- ☐ Please be sure your policy number(s) is/are written on the claim form.
- ☐ **This claim form packet is used for filing for your Short Term Home Health Care and Optional Benefit Riders.**
- ☐ **If you are filing a claim for benefits under the Terminal Illness rider**, please use the specific claim form packet for the Terminal Illness Rider.
- ☐ The claim form must be completed and signed by the insured or responsible party.

  Please attach Power of Attorney or Guardian Papers if applicable.
- ☐ The **HIPAA Authorization** to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission so that we can contact your medical provider on your behalf if additional information is needed.
- ☐ Included Physician's Home Health Certification (Form PHHC) must be complete.
- ☐ We may also need to obtain on your behalf the Care Plan and the HHC Agency licensing.
- ☐ If you signed a benefits assignment with the provider and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.
- ☐ Include any **itemized bills** for consideration. We do not pay on advanced billings.

An itemized bill indicates:

Attach itemized bills (we don't pay advanced billings) to the claim form. For faster processing, please be sure you answer ALL questions on the claim form. Include Aide note(s).

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

PLEASE NOTE: Your Policy may have a Pre-Existing Conditions Limitation and a 2 Year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.

***Processing delays may result if you don't provide all the required information**.

Please send all information to:

United National Life
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 699-1048
OR Email to: Claims@unlinsurance.com

- ☐ We suggest you make photocopies of any information sent for your own records.

For assistance, please contact our Customer Service Department (800) 207-8050

Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or fax to: (847) 699-1048
Or email to: Claims@unlinsurance.com
For Customer Service, please call: (800) 207-8050

SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders

COMPLETED BY THE INSURED

Policy Number(s) | Policy Holder's Name

Claimant/Patient Name | Date of Birth

Address (Street) (City) (State) (Zip Code)

Phone | Email

TYPE OF BENEFIT(S) FOR WHICH THE CLAIM IS BEING MADE

- ☐ Skilled Nursing Care (RN)
- ☐ General Nursing Care (LPN/LVN)
- ☐ Physical or Occupational Therapy
- ☐ Speech Pathology
- ☐ Chemotherapy Specialist
- ☐ Enterostomal Therapy
- ☐ Respirational Therapy
- ☐ Medical Social Services

OPTIONAL RIDERS:

- ☐ Hospital Indemnity
- ☐ Outpatient Surgical
- ☐ Terminal Illness (Use special claim form packet)
- ☐ Cancer Lump Sum Benefits
- ☐ Ambulance Benefits
- ☐ Critical Accident (See page #3)

Date symptoms first appeared: ___/____/____ Date of first visit with physician: ___/____/____

Date of actual diagnosis: ___/____/____ What was diagnosis: _____

Have you ever had this condition before? ☐ Yes ☐ No If yes, what date: ___/____/____

Were you hospitalized for this condition? ☐ Yes ☐ No If yes, what were the dates: ___/____/____ to ___/____/____

Were you admitted through the Emergency Room? ☐ Yes ☐ No Was any type of surgery required? ☐ Yes ☐ No

If hospitalized, what was the name and address of hospital/medical center? _____

_____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center?: _____

_____

Did you have any surgery performed? ☐ Yes ☐ No If yes, what type of surgery:_____

Your Primary Care (or family doctor) name, address and telephone number:_____

_____

CONTINUED:

Were there any other physicians seen during the last two (2) years? *(if more space is needed, please attach separate sheet)*
If so, please provide their names, addresses and phone numbers:

Physicians name	Type of doctor	Address and telephone number
Physicians name	Type of doctor	Address and telephone number
Physicians name	Type of doctor	Address and telephone number

FOR HOME HEALTH CARE OR SKILLED NURSING HOME:

If you are filing for Home Health Care or Skilled Nursing Home benefits, please complete the following:

Name, address and telephone of **Skilled Nursing Home** facility: _____

_____

Name, address and telephone for **Home Health Care** agency: _____

_____

ACCIDENT CLAIM FORM FOR CRITICAL ILLNESS RIDER:

Date of accident: ____/____/____ Time of accident: _____AM _____PM

Location of accident: _____ Work related? ☐ Yes ☐ No

What was your injury? _____ Did you suffer a fracture/break? ☐ Yes ☐ No

Was this a sports related accident? ☐ Yes ☐ No If yes, what sport was involved: _____

Were you treated at an Emergency Room/Immediate Care Facility? ☐ Yes ☐ No If Yes, what date: ____/____/____

Name and address of facility: _____

Were you admitted as an inpatient? ☐ Yes ☐ No If yes, name of facility:_____

Please provide the name, address and telephone number of physician(s) who treated you:

Physicians Name	Address	Phone Number

SIGNATURE FOR CLAIM PACKET:

Is Medicaid involved in the coverage of your care, or medical expenses? ☐ Yes ☐ No

<u>If yes</u> and Medicaid is involved in the coverage of my expenses, I HERBY AUTHORIZE United National Life Insurance Company of America to coordinate benefits related to my bills directly with the Hospital or Medical Provider. I understand that I am financially responsible for any charges not covered by the policy.

In addition, I understand that this claim form information will be used by United National Life Insurance Company of America for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Insured Member Signature **Print Name:** **Date:**

Mail claims to:
P.O. Box 1144
Glenview, Illinois 60025
Or fax to: (847) 699-1048
Or email to: Claims@unlinsurance.com
For Customer Service, please call: (800) 207-8050

PHYSICIAN'S HOME HEALTH CERTIFICATION

Policy No.	**Certification Period** **From:** **To:**
Patient's Name and Address	1. Physician's Name and Address
Date of Birth: Sex: ☐ M ☐ F	2. Physician's Tax I.D. No.

3. ICD-10-CM	Principal Diagnosis	Date	5. Prior Hospital Confinement for which Subsequent Home Health Care was needed: A. From:
4. ICD-10-CM	Other Pertinent Diagnosis	Date	To: B. Name of Hospital and Address

6. Can the patient perform, without assistance of another person, any of the following Activities of Daily Living (ADL's)?

	YES	NO	
A.	☐	☐	Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps);
B.	☐	☐	Continence (bladder control);
C.	☐	☐	Dressing (tying shoes, buttoning buttons or clasps);
D.	☐	☐	Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach);
E.	☐	☐	Toileting (maintaining adequate bathroom hygiene and toilet habits); or
F.	☐	☐	Transferring to or from bed or chair

If any of the above answered "NO" please furnish test results.

7. Does the patient require continuous supervision and assistance due to a Cognitive Impairment (a deficiency in the ability to think, perceive, reason, and/or remember, which has been evaluated and measured through clinical evidence and standardized tests)? ☐ **YES** ☐ **NO**

If "YES," please furnish test results.

8. Home health services performed:

- ☐ Skilled Nursing (Skilled nursing care provided by a registered nurse (RN))
- ☐ General Nursing (General nursing care provided by a licensed practical nurse (LPN) or licensed vocational nurse (LVN))
- ☐ Physical Therapy
- ☐ Speech Pathology
- ☐ Occupational Therapy
- ☐ Chemotherapy Specialist Services
- ☐ Enterostomal Therapy
- ☐ Respiration Therapy
- ☐ Medical Social Services
- ☐ Home Health Care Aide (any individual, other than a member of the patient's immediate family, working under the supervision of an RN, who is qualified, by training and experience, to provide assistance with the Activities of Daily Living listed in 6 above and has been certified by the appropriate regulatory authority).
- ☐ Other (specify)

9. Other Remarks:

10. I ☐ certify ☐ recertify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.

11. Certifying Physician's Signature Date Signed

United National Life Insurance Company of America
P.O Box 1144, Glenview, Illinois 60025
1-800-207-8050

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by UNL for purposes of obtaining information necessary to process a claim for benefits.

Policy/Certificate # _____

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide United National Life Insurance Company of America (UNL) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that United National Life Insurance Company of America may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by UNL in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Patient _____ Date of Birth _____

Signature of Patient _____ Date _____

(Please Print) Name of Authorized Representative, or Next of Kin _____

Relationship of Authorized Representative or Next of Kin to Patient _____

Signature of Authorized Representative or Next of Kin _____ Date _____

Dear Insured: *Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Connecticut
Georgia
Hawaii
Iowa
Illinois
Kansas
Massachusetts
Michigan
Missouri
Mississippi
Montana
Nebraska
North Carolina
North Dakota
Nevada
South Carolina
South Dakota
Utah
Vermont
Wisconsin
Wyoming

Generic Fraud Warning (to be used for above states only) Any person who knowingly presents a fraudulent claim containing any false or misleading information is guilty of insurance fraud and may be subject to fines and confinement in prison.

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 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.

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 insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 – 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.

Kentucky – A 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 – 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.

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.

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 RSA 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.

Ohio and Oregon – 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 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.

Tennessee, Virginia and Washington State – 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.

Texas – 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.