GTL | GUARANTEE TRUST LIFE

SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders CLAIM FORM

Please read the important information below:

- ☐ **This packet is used for filing for your Short Term Home Health Care or Rider Benefits.** Please be sure your policy number(s) is/are on all documents.
- ☐ The claim form should 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 for additional information needed.
- ☐ The **Physicians Home Health Certification** form must be completed by the ordering physician.
- ☐ Include any **itemized bills** for consideration. We do not pay on any advanced billings. Include any Aide note(s) for your care. Please be sure you answer ALL questions on the claim form.

An itemized bill should contain:

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.

- ☐ We will also need to obtain on your behalf the Care Plan and the HHC Agency licensing.
- ☐ **If you are filing only for your Prescription Drug Benefits, please use just the Prescription Drug Filing Form** provided on the website, as all these additional forms and information are not required.
- ☐ Please send all information to:

Guarantee Trust Life Insurance
P.O. Box 1144
Glenview, Illinois 60025
OR Fax to: (847) 904-5723

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.

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.

- **Processing delays may result if you do not provide all the above information.**
- We suggest you make photocopies of any information sent for your own records.

For assistance, please contact our Customer Service Department (800) 338-7452

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SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders CLAIM FORM

TO BE COMPLETED BY THE INSURED

Policy Number(s) _____ Policyholder'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/General Nursing Care (RN/LPN/LVN)
- ❒ Physical Therapy
- ❒ Speech or Occupational Therapy
- ❒ Respirational Therapy
- ❒ Accident or Sickness Hospitalization
- ❒ Enterostomal Therapy
- ❒ Chemotherapy Specialist
- ❒ Medical Social Services
- ❒ Optional Rider benefits below:
  - ❒ Ambulance ❒ Critical Accident

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

Date of actual/definitive diagnosis: ___/___/___

Have you ever had this illness/condition before? ❒ Yes ❒ No If yes, date? ___/___/___

If yes, what's the name, address and telephone number of physician? _____

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

Are you now, or have you received home health care services before? If yes, when: ___/___/___

What condition were/are you receiving care for? _____

Have you ever been diagnosed with a cognitive illness? What diagnosis: _____ When: ___/___/___

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

Where 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:

Physician name _____ type of doctor _____ address and phone number _____

Physician name _____ type of doctor _____ address and phone number _____

Physician name _____ type of doctor _____ address and phone number _____

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SHORT-TERM HOME HEALTH CARE CLAIM FORM and Optional Riders CLAIM FORM

TO BE COMPLETED FOR AN ACCIDENT CLAIM

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

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

What was your injury?: _____ Did you suffer a fracture or break?: ❒ Yes ❒ No

Was this a sports related accident? ❒ Yes ❒ No If yes, what sport? _____

Description of accident: _____

_____

_____

_____

Were you treated in an ER or Immediate Care Facility? ❒ Yes ❒ No

If yes, please provide date and the name and address of the facility: Date ____/____/____

Name and address of facility: _____

Were you admitted as an inpatient for your injuries: ❒ Yes ❒ No

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

_____

Physician name Address Phone Number

I understand that this information will be used by Guarantee Trust Life Insurance Company 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:**

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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: To: B. Name of Hospital and Address
4. ICD-10-CM	Other Pertinent Diagnosis	Date	

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

	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 are 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

Guarantee Trust Life Insurance Company
P.O Box 1144, Glenview, Illinois 60025
1-800-338-7452

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by GTL 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 Guarantee Trust Life Insurance Company (GTL) 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 Guarantee Trust Life Insurance Company 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 GTL 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.*

General 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.