Trustmark
INSURANCE COMPANY

Long Term Care/ Home Health Care Claim Form

Attn: Life Claims
100 North Parkway • Ste. 200 • Worcester, Massachusetts 01605
1-800-918-8877 • FAX 508-853-0310
www.trustmarkins.com/customersolutions

INSTRUCTIONS: IN ORDER TO PROVIDE PROMPT SERVICE TO YOUR REQUEST FOR LONG TERM CARE, HOME HEALTH CARE AND/OR, ADULT CARE BENEFITS, COMPLETE PART I IN ITS ENTIRETY, **SIGN AND DATE THE AUTHORIZATION** AND HAVE YOUR PHYSICIAN COMPLETE PART II.

PART I – STATEMENT OF THE INSURED (PLEASE PRINT OR TYPE)

CERTIFICATE/POLICY # ____________

INSURED'S NAME ____________ (FIRST) (MIDDLE) (LAST)

DATE OF BIRTH ______ TELEPHONE # ____________ (AREA) (#)

SOCIAL SECURITY # ____________

INSURED'S ADDRESS ____________ (STREET) (CITY) (STATE) (ZIP)

EMPLOYER/SUPERVISOR ____________ (NAME) (ADDRESS) PHONE # ____________

DATE LAST WORKED ____________

BENEFIT(S) APPLIED FOR: ❒ LONG TERM CARE ❒ HOME HEALTH CARE ❒ ADULT DAY CARE ❒ ASSISTED LIVING

NAME AND ADDRESS OF AGENCY PROVIDING CARE

____
(NAME) (ADDRESS) (DATE OF SERVICE)

PHYSICIAN WHO IS CERTIFYING CARE

____
(NAME) (ADDRESS) (DATE OF SERVICE)

DOCTORS CONSULTED OTHER THAN CERTIFYING PHYSICIAN, FOR PRESENT CONDITION:

____
(NAME) (ADDRESS) (PHONE #) (DATES)

NAME OF HOSPITAL ____________ DATE ADMITTED ______ DATE DISCHARGED ______

DATE OF ACCIDENT/ILLNESS	DESCRIPTION OF ACCIDENT/ILLNESS:

IS THIS A WORK-RELATED INJURY OR ILLNESS? ❒ YES ❒ NO	PLACE OF ACCIDENT

NATURE AND EXTENT OF INJURY OR ILLNESS	DATE OF FIRST TREATMENT

HAVE YOU HAD ANY OTHER MEDICAL ATTENTION IN THE PAST FIVE YEARS? ❒ YES ❒ NO. IF YES, PLEASE COMPLETE.

( )
____
DOCTORS NAME ADDRESS PHONE #

____
DIAGNOSIS DATES OF TREATMENT

WHAT ACTIVITIES OF DAILY LIVING ARE YOU CURRENTLY UNABLE TO PERFORM WITHOUT ASSISTANCE?
BATHING ___ TOILETING ___ DRESSING ___ WALKING ___ EATING ___ TAKING MEDICATION ___ GETTING IN AND OUT OF BED___

IF SO, PLEASE EXPLAIN ____________

IF PATIENT/INSURED IS INCOMPETENT, PLEASE PROVIDE NAME, ADDRESS, AND NOTARIZED PAPERS FOR GUARDIAN, CONSERVATOR, POWER OF ATTORNEY, OR TRUSTEE WHO IS RESPONSIBLE FOR FINANCIAL AFFAIRS.

NAME ____________ ADDRESS ____________

*****COMPLETE AND SIGN DISCLOSURE AUTHORIZATION ON THE LAST PAGE*****

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Your prompt completion of all items on this form will help us help your patient

PART II – ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME | AGE

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) | DATE FIRST CONSULTED YOU FOR THIS CONDITION | IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES AND DIAGNOSIS.

NAME & ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCES (e.g. PUBLIC HEALTH AGENCY) | HAS PATIENT ANY CHRONIC OR CONSTITUTIONAL DISEASE, PHYSICAL DEFECT OR DEFORMITY ❒ YES ❒ NO IF SO, DESCRIBE

PATIENT'S DIAGNOSIS (DX CODE):___

THE PATIENT NEEDS ASSISTANCE WITH THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)
GETTING IN & OUT OF BED __ WALKING __ BATHING __ EATING __ TAKING MEDICATION __ GOING TO THE TOILET __ DRESSING __

COGNITIVE IMPAIRMENT ❒ YES ❒ NO

DOES PATIENT SUFFER FROM ANY MENTAL, PSYCHONEUROTIC OR PERSONALITY DISORDER WITHOUT DEMONSTRABLE ORGANIC DISEASE?
❒ YES ❒ NO IF YES, PLEASE EXPLAIN.___

TYPE OF SERVICE: ❒ LONG TERM CARE ❒ HOME HEALTH CARE ❒ ADULT DAY CARE ❒ ASSISTED LIVING

AGENCY PROVIDING HOME HEALTH CARE

NAME___ ADDRESS ___ ZIP ___

PHONE NUMBER:___ LICENSE NUMBER:___

ADULT CARE CENTER

NAME___ ADDRESS ___ ZIP ___

PHONE NUMBER: ___ LICENSE NUMBER: ___

COMPLETE FOR LONG TERM CARE/ ASSISTED LIVING:

NAME OF FACILITY: ___ PHONE ( )___

ADDRESS: STREET ___ CITY ___ STATE ___ ZIP ___

TAX I.D. # ___

LICENSED BY THE STATE? ❒ YES ❒ NO LICENSE # ___

AS WHAT? (PLEASE CHECK) ❒ SKILLED NURSING CARE ❒ INTERMEDIATE NURSING CARE
❒ RESIDENTIAL ❒ OTHER ___
(SPECIFY)

WHAT IS YOUR PROGNOSIS FOR RECOVERY AND/OR CESSATION OF TREATMENT?___

EXPECTED LENGTH OF CONFINEMENT, SERVICE? FROM ___ TO ___

PLEASE PRINT

PHYSICIAN'S NAME AND DEGREE(S) ___

PHONE NUMBER: ___ FAX NUMBER: ___

ADDRESS: STREET ___ CITY ___ STATE ___ ZIP ___

I CERTIFY THAT THE ABOVE CONFINEMENT, CARE OR SERVICE IS MEDICALLY NECESSARY.

FULL SIGNATURE ___ DATE ___

State Required Fraud Warnings

New Hampshire Residents: 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.

Arizona Residents - 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.

California Residents - 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 Residents - 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 purposes 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.

Kansas and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Kentucky Residents - 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.

Arkansas, Louisiana and West Virginia Residents: 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.

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

FRAUD WARNING FOR WASHINGTON, MAINE, TENNESSEE AND VIRGINIA RESIDENTS: 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 AND DENIAL OF INSURANCE BENEFITS.

FRAUD WARNING FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY 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.

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

Fraud Warning for Oklahoma, as well as for the residents of all states not specifically listed 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.

Fraud Warning for Alaska Residents - 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.

Fraud Warning for District of Columbia Residents - 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.

Fraud Warning for New Mexico Residents - 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.

Fraud Warning for Ohio Residents - 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.

Fraud Warning for Texas Residents - 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.

Fraud Warning for Maryland Residents - 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.

DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____________________________

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may nor longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

RESIDENTS OF NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Residents of Florida – Any person who knowing and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Residents of NY – 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 or each such violation.

Date: _______________________ Signature: ____

Date of Birth______/______/______ Relationship if other than insured:________________________________