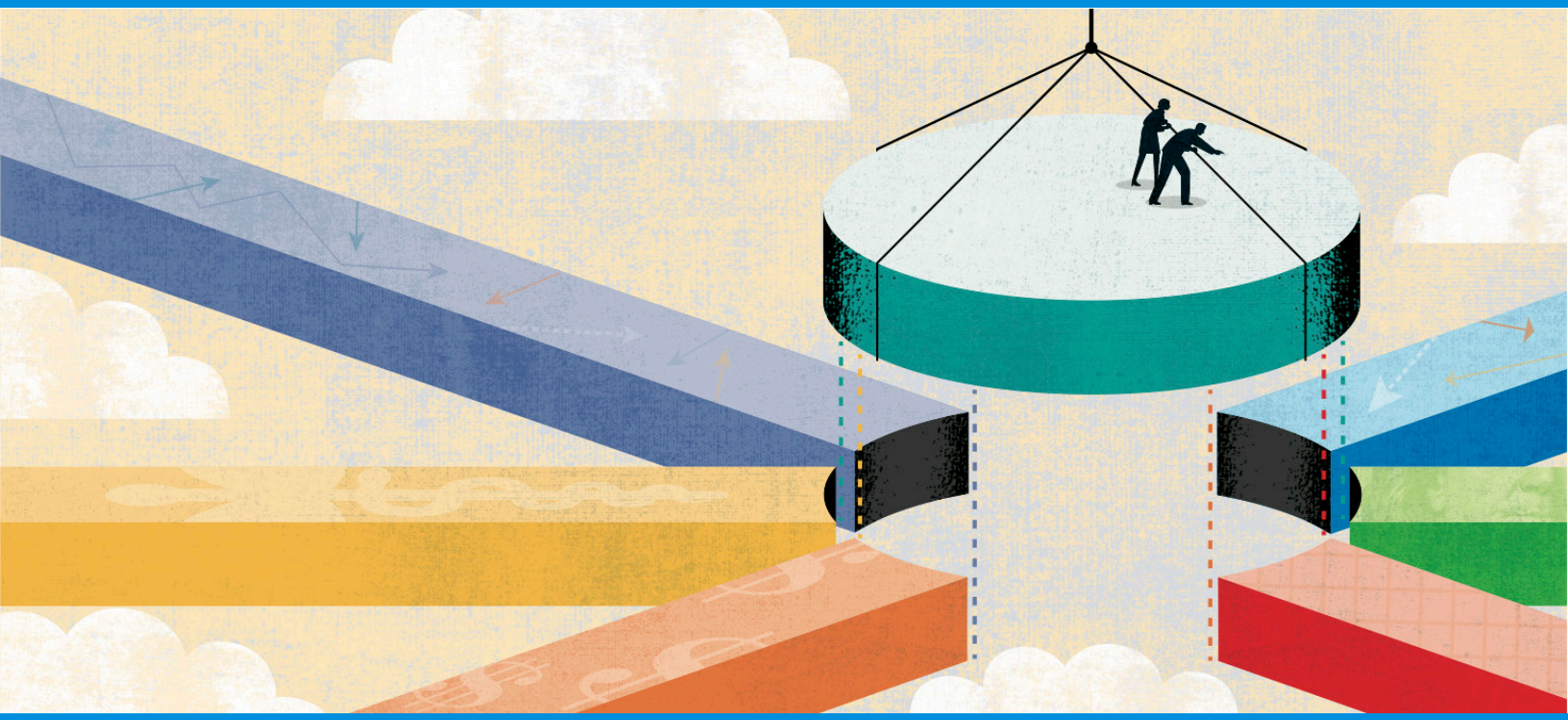
ManhattanLife™

Standing By You. Since 1850.

Short Term Care Claims Packet



Underwritten by:
Standard Life and Casualty Insurance Company
ManhattanLife Insurance and Annuity Company

STC-CF 0624

Short Term Care and Optional Rider Claim Forms

Please read the important information below:

This packet is used for filing your OmniFlex Short-Term Care benefit and optional rider claims. 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, in the event we must contact your medical provider for additional information as needed.

The Physician's Health Certification form must be completed by the ordering physician.

Include any itemized statements, UB04 or Health Care Financing Administration (HCFA) forms for consideration. We *do not pay on any advanced billing*. Include any Aide note(s) for your care. Please be sure you answer ALL questions on the claim form.

An itemized statement contains:

1. The date(s) of treatment
2. The type(s) of service
3. The diagnosis
4. The medical provider's name and address.

If you are only filing a claim for your Prescription Drug Benefits, please use the separate Prescription Drug Claim Form provided on the website.

Please send all information to:

ManhattanLife Claims Department
P.O. Box 925568
Houston, Texas 77292-5568

Or fax to: (713) 583-2738

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.
- For your own records, we suggest you make photocopies of any information or documentation that you send or receive.

For assistance, please contact our Customer Service Department (800) 672-4535

To be completed by the insured

Policy Holder Name				Date of Birth
Policy Number				
Address	(Street)	(City)	(State)	(Zip Code)
Phone		Email		

Type of benefit(s) for which the claim is being made:

☐ **Daily Benefit (Facility Care): (Complete parts A & B on next page)**

- ☐ Nursing Facility
- ☐ Assisted Living Facility
- ☐ Hospice Care
- ☐ Bed Reservation

☐ **"Fast-50" Benefit *(Facility Care or Home Care Benefit) (Complete parts A, B & C on the next page)***

(Note: If you elect to receive the Fast-50 Benefit, we will pay fifty percent (50%) of your per day Facility Care, or Home Health Care Benefit amount shown on the policy schedule. The elimination period for the Facility Care Benefit and Home Health Care Benefits, if any, is waived if you elect to receive this benefit. If you are eligible for the Facility Care Benefit or Home Home Health Care and elect the Fast-50, we will pay the Fast-50 Benefit for each day you meet the coverage requirements. If you switch from the Fast-50 to the Facility Care or Home Health Care benefits, you still must satisfy the elimination period.)

☐ **Home Health Rider: (Complete parts A, B & C on the next page)**

- ☐ Nursing Care (RN/LPN/LVN)
- ☐ Chemotherapy Specialist
- ☐ Enterostomal Therapy
- ☐ Home Health Care Aide
- ☐ Respiratory Therapy
- ☐ Speech Pathology
- ☐ Medical Social Services
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Other

☐ **Hospital Indemnity Rider: (Complete part A on next page)**

Date Range of Hospitalization From: _____ To: _____

Reason for Hospitalization: _____

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 of previous diagnosis? _____

If yes, what is the name, address, and telephone number of physician that previously provided the diagnosis? _____

_____

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: _____

(A cognitive illness is classified as the inability to think, understand, learn, and remember on one's own.)

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

_____

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:

Physician Name _____ Type of Doctor _____

Address and Phone Number _____

Physician Name _____ Type of Doctor _____

Address and Phone Number _____

I understand that this information will be used by Standard Life and Casualty Insurance Company and ManhattanLife Insurance and Annuity Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the questions on page 3 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's Signature: _____ Print Name: _____ Date: _____

Physician's Health Certification

PART A

Policy Number			
Patient's Name		Patient's Address	
Date of Birth	Sex: ☐ Male ☐ Female	Physician's Tax I.D. Number	
ICD-9-CM	Principal Diagnosis		Date
ICD-10-CM	Other Pertinent Diagnosis		Date

PART B

Home Healthcare Services Certified:

From:_____ To: _____

☐ Nursing Care (RN/LPN/LVN)	☐ Home Health Care Aide	☐ Medical Social Services
☐ Chemotherapy Specialist	☐ Respiratory Therapy	☐ Occupational Therapy
☐ Enterostomal Therapy	☐ Speech Pathology	☐ Physical Therapy

☐ Other (Specify):_____

Can the patient perform any of the following Activities of Daily Living (ADLs) without the assistance of another person?

PART C

Yes	No	
☐	☐	Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps)
☐	☐	Dressing (tying shoes, buttoning buttons or clasps)
☐	☐	Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach)
☐	☐	Toileting (maintaining adequate bathroom hygiene and toilet habits)
☐	☐	Transferring to or from bed or chair
☐	☐	Continence (the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag))

Does the patient require continuous supervision & assistance due to a Cognitive Impairment? ☐ Yes ☐ No

I certify 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.

Certifying Physician's Signature _____ Date Signed _____

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation related to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

For information or to check claim status, call 1-800-672-4535.

HIPAA AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared by Standard Life and Casualty Insurance Company and ManhattanLife Insurance and Annuity Company for the purpose of obtaining information necessary to process a claim for benefits.

Name: _____ Policy No:_____

Date of Birth:_____

I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature regarding my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law.

I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule. I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____

Date Authorization Signed | Signature of Claimant or Authorized Personal Representative

Mail Claims to:
P.O. Box 925568, Houston, Texas 77292-5568
Or fax to: (713) 583-2738
For Customer Service, please call (800) 672-4535

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