

Helpful Hints



CONSECO.

HOSPITAL INDEMNITY INSURANCE CLAIM FORMS

Failure to complete the required sections may result in a delay in processing this claim.

We value you as a policyowner and want to make the process of filing a claim as fast and as simple for you as possible. To assist you with the process, we are providing these instructions:

HOW TO COMPLETE THE CLAIM FORM

- ✓ Be sure to include the policy/certificate number.
- ✓ Please complete each box of the claim form – indicate “N/A” if a response is not applicable.
- ✓ The patient or guardian must sign the claim form.

SUPPORTING DOCUMENTATION

Failure to submit required documentation may result in delay in processing this claim.

- ✓ Submit all bills related to this claim. All bills should be itemized and should include the diagnosis, services rendered and actual charges.
- ✓ If you were treated in the Emergency Room, please submit a copy of the Emergency Room report.
- ✓ If the injury resulted from an auto accident, a copy of the accident report is required.
- ✓ We require a copy of the police accident report and toxicology report (if applicable) for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.
- ✓ Send a copy of your hospital bill (UB92, UB04 or CMS 1450) that indicates the number of days confined.
- ✓ Please include a certified copy of the death certificate if the patient is deceased.

WHERE TO SUBMIT CLAIMS

Mail all Hospital Indemnity Insurance Claims to:

Claim Processing
PO Box 2024
Carmel IN 46082-2024

Phone calls can be directed to (800) 981-8404.

THREE COMMON REASONS WHY CLAIMS ARE DELAYED

1. Missing itemized bills or other required supporting documentation
2. Claim form not completed in its entirety – a response or “N/A” in each box
3. Policy/Certificate numbers not included on the claim form and/or other supporting documentation



HOSPITAL INDEMNITY INSURANCE CLAIM FORM

Failure to complete the required sections may result in a delay in processing this claim.

Please select the appropriate company:

- Conseco Insurance Company
- Conseco Health Insurance Company
- Conseco Senior Health Insurance Company
- Washington National Insurance Company

POLICYOWNER INFORMATION

POLICY NUMBER / CERTIFICATE NUMBER

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE ____/____/____	PHONE NUMBER ()
ADDRESS <input type="checkbox"/> Check box if this is a new permanent address		
CITY	STATE	ZIP

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL		
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE ____/____/____	PHONE NUMBER ()		
PATIENT'S EMPLOYER	PATIENT'S OCCUPATION	PATIENT'S HEIGHT	PATIENT'S WEIGHT	
EMPLOYER ADDRESS		CITY	STATE	ZIP
HOSPITAL STAY, NAME: DATES: FROM ____/____/____ TO ____/____/____		NURSING HOME STAY, NAME: DATES: FROM ____/____/____ TO ____/____/____		
DATE YOU FIRST BECAME ILL ____/____/____	DATE OF ACCIDENT ____/____/____	DATE YOU FIRST SAW ANY DOCTOR FOR THIS CONDITION ____/____/____		

IF ACCIDENT, HOW DID IT HAPPEN?

PLEASE CHECK IF FILING FOR THE FOLLOWING BENEFIT(S): <input type="checkbox"/> EMERGENCY TRANSPORTATION <input type="checkbox"/> PET BOARDING	DID YOU OR WILL YOU FILE A WORKER'S COMPENSATION CLAIM? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IMPORTANT – IS THE PATIENT COVERED BY ANOTHER HOSPITAL/MEDICAL COVERAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Group <input type="checkbox"/> Individual	POLICY NUMBER
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OTHER INSURANCE COMPANY NAME AND ADDRESS	CITY	STATE	ZIP
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IF CHILDBIRTH, BABY'S NAME	BIRTH DATE ____/____/____	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
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PHYSICIAN INFORMATION

TREATING PHYSICIAN'S NAME	PHONE NUMBER ()	FAX NUMBER ()
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ADDRESS	CITY	STATE	ZIP
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REGULAR FAMILY PHYSICIAN'S NAME	PHONE NUMBER ()	FAX NUMBER ()
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ADDRESS	CITY	STATE	ZIP
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IMPORTANT PLEASE SIGN

SIGNED (Patient or parent if child) _____ DATE _____