



HOSPITAL INDEMNITY CLAIM FORM

INSTRUCTIONS

For Customer Service, call 1-866-317-0167 (toll-free)

1. Answer every question within PART A – EMPLOYEE’S STATEMENT.
2. Sign PART A – EMPLOYEE’S STATEMENT under AUTHORIZATION TO RELEASE INFORMATION.
3. Attach all bills, including hospital bills, for charges that you refer to on this claim form. These bills must identify the patient's name, conditions treated (diagnosis), type of treatment, date each expense was incurred, and itemized charges.
4. Mail this form and the attached bills to: **America’s Choice Healthplans, LLC**
13111 NW Freeway, Suite 510
Houston, TX 77040

PART A - EMPLOYEE’S STATEMENT			Employer’s Name: Conroe Independent School District	
FULLY COMPLETE FOR ALL CLAIMS	Employee’s Name (Please Print)	Group Number 71200	Date of Birth	Social Security Number
	Address: Street and No.		City	State Zip Code
	Phone Number	This claim is on: ☒ Myself	Are you covered under another plan? ☐ Yes ☐ No	
	What was the sickness or injury?		On what date did it begin?	Date of first expense for this condition:
	Are Benefits payable from any other source (including Military, Automobile, Liability Insurance, School Accident Insurance) for the expense submitted? ☐ Yes ☐ No		If "Yes", (a) Other Source: _____ (b) Address: _____ (c) Policy No. or I.D. No. _____	
AUTHORIZATION TO RELEASE INFORMATION				
I hereby authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct and that it is unlawful to fill out this form with information that I know is false or to leave out facts I know are important. This authorization or photo static copy of the original shall be valid for one year from the date of signature. I understand that I may request to receive a copy of this authorization. ➤ _____ Employee/Patient _____ Date				
AUTHORIZATION TO PAY PROVIDER			AUTHORIZATION TO PAY PLAN PARTICIPANT	
I authorize payment of all medical benefits for services rendered from those physicians or providers described below and/or as indicated on the enclosed bills. I understand that I am financially responsible to the provider(s) for charges not covered by the authorization. ➤ _____ Employee’s Signature _____ Date			Please sign below for payment to go directly to Covered person. ➤ _____ Employee’s Signature _____ Date	