Claim Submission Form

1. To ensure your claim gets processed efficiently, please check the appropriate box(es) for the coverage you are filing a claim under:

☐ Physician Visit	☐ In-Patient (Daily Hospital Confinement)	☐ Out-Patient (Surgery)
☐ Hospital Admission (1 time per policy period	☐ In-Patient (Intensive Care)	☐ Out-Patient (Surgery - Anesthesia)
☐ Emergency Room (Sickness or Injury) Daily	☐ In-Patient (Surgery - Anesthesia)	☐ Out-Patient (Diagnostic Radiology)
☐ Skilled Nursing	☐ In-Patient (Surgery)	☐ Out-Patient (Diagnostic Labs)

2. Please complete the claim form below in its entirety. (If information is missing, it may delay the processing of your claim.)
3. Be sure to sign and date the authorization and claim form.
4. Provide the date and description of your qualified illness or surgery.
5. Please provide Physicians documentation to support your visit.
6. If you are filing for either, please:
   a. Provide documentation of your date of treatment services.
   b. Provide all bills associated with your claim, including treatment dates, total charges, diagnosis, and treatment codes.
   c. If you are filing for Hospital admission/confinement benefits, include the hospital bill with admission and discharge dates.
   d. If you are filing for specific qualified benefit, provide the objective test findings, to include X-ray reports, MRIs, and CT scans. If filing for surgery benefits, provide the operative report.

Holder/Claimant's Statement

Employer's Name or Association Member	Member's Email Address	Member's Phone *(with area code)*	Member's Biological Sex ◯ Male ◯ Female

Member's First Name	Member's Last Name	Member's Date of Birth	Member's Social Security Number

Member's Address *(Same as where check is to be sent.)*	Member's City	Member's State	Member's Zip Code

Full Name *(If filing on behalf of a dependent minor covered under this policy.)*	Relationship to Member

Describe when and how your illness occurred.

Is the qualified event or sickness related to the member's occupation? ◯ Yes ◯ No	Has a workers compensation claim been filed? ◯ Yes ◯ No

Authorization

DOCTOR TREATED OR REFERRED BY WITHIN THE LAST 90 DAYS

Date symptoms first appeared	Date treated	Full Name	Phone	Email address (if applicable)

Address	City	State	Zip Code

HOSPITALIZED WITHIN THE LAST 90 DAYS

Date symptoms first appeared	Date treated	Facility Name	Phone	Email address (if applicable)

Address	City	State	Zip Code

DISCLOSURE STATEMENT:

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.

Insured Member's Signature	Date

SUBMIT

Click on the "SUBMIT" button, to automatically open an email with this form attached.
Be sure to attach all supporting bills and receipts before sending to claims@ovation-health.com.