CONSECO COMPANIES

Helpful Hints

From the Claims Department to guide you through filing your Cancer claim

We value you as a customer 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're providing these helpful hints:

SUBMITTING A CLAIM

When submitting a claim, attention to the following details will assure that your claim moves quickly and benefits due are processed without delay.

- Submit a fully completed and signed claim form.
- Be sure to include the provider's name, address and phone number with all claims.
- Provide the first diagnosis date for the health condition for which bills are being submitted.
- Itemized bills are required that include dates of service, procedure codes and diagnosis codes before benefits can be considered (e.g. CMS 1500, UB04, etc.)
- Pathology reports must be submitted for all biopsies before benefits can be considered.
- For radiation/chemotherapy benefits, an itemized bill is required showing each date of treatment with the charges for each date before benefits can be considered.

TOP 3 REASONS CLAIMS MAY BE DELAYED

1. *Itemized bills* are not sent with the claim form.
2. *Pathology report* is not sent with the claim form.
3. *Procedure and/or diagnosis codes* are not included on the itemized bills.

WHERE TO SUBMIT CLAIMS

Mail all cancer *claims* to:

Claim Processing
Conseco Companies
P.O. Box 2024
Carmel, IN 46082

Express packages should be addressed to:

Attn: Claim Processing 2024
Conseco Companies
11825 N. Pennsylvania Street
Carmel, IN 46032

Faxes for the health claims should be sent to (317) 208-8656.

Phone calls may be directed to customer service at (800) 824-2726.

Please note: Explanation of Benefits (EOBs) from another insurance company cannot be used to support your claim. Copies of the original bills must be submitted.

CCF01

Conseco Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

CANCER CLAIM FORM

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

This form can be used for the following companies:
Conseco Insurance Company Conseco Life Insurance Company Conseco Health Insurance Company
Washington National Insurance Company

POLICY OR CERTIFICATE NUMBER _____

SECTION A: OWNER INFORMATION (Please print)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE __/__/__	PHONE NUMBER (HOME) ( )
ADDRESS ☐ Check box if this is a new permanent address		
CITY	STATE	ZIP
IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:		
PLACE OF EMPLOYMENT	PHONE NUMBER (WORK) ( )	
ADDRESS		
CITY	STATE	ZIP

PATIENT INFORMATION (If different than owner; Please print)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE	PHONE NUMBER ( )
IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:		
PLACE OF EMPLOYMENT	PHONE NUMBER (WORK) ( )	
☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED ☐ OTHER	RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐ CHECK IF INSURED IS DECEASED – DATE DECEASED __/__/____

Please provide the names, addresses and phone numbers of any physician who has treated you or with whom you have consulted in the last five years:

_____

_____

Transportation/Lodging Information: To be completed if you are filing a claim for transportation or lodging:

Date	To/From	Roundtrip Mileage	Type of Treatment

Please be sure to include the following information along with this claim form:

☐ **Positive Pathology Report** ☐ **Itemized bills form from facility including diagnosis and/or procedure codes and charge amounts** (Itemized bills may include but are not limited to the following claim forms: UB04,CMS 1500, etc.)

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of executing this form.

_____ _____ _____
PATIENT'S SIGNATURE (or legal representative) RELATIONSHIP DATE

_____ _____
OWNER'S SIGNATURE (or legal representative) DATE

CCF03

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For your protection, the laws of several states require the following statement:
Fraud Warning: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

AK, 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.

AZ 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.

AR 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.

CA 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.

CO 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 purpose 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.

DE Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

DC 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.

FL Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

IN Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY Residents: Any 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.

LA 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.

ME 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 or a denial of insurance benefits.

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

NH 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, as provided in 638:20.

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

NM 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.

CCF05

Conseco Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

NY Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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 for such violation.

OH 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.

OK Residents: 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.

OR 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 may be guilty of insurance fraud.

PA Residents: 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 subjects such person to criminal and civil penalties.

PR Residents: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RI 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.

TN 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 include imprisonment, fines and denial of insurance benefits.

RI 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 prison.

VA 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 include imprisonment, fines and denial of insurance benefits.

WA 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 include imprisonment, fines and denial of insurance benefits.

WV 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.

CCF06

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Authorization to Release Information

Health Insurance Claims Processing--pursuant to the HIPAA Privacy Rule

I. My information - the individual whose information will be released

Name: Date of Birth: Policy Number:

Address:

II. Disclosing Party - organization authorized to release my information

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy or pharmacy-related organization, health plan or insurance company

III. Description of my information authorized for release

Any information related to my past, present or future medical care or treatment (including mental health, communicable disease, HIV/AIDS and substance abuse records, but excluding psychotherapy notes), unless specifically limited by me as follows:

_____.

IV. Purpose of release - describing how my information will be used by the Receiving Party after it is released

Processing my health insurance claim(s)

V. Duration of authorization

This authorization will expire 24 months from the date written below, unless I specify an alternate expiration date here: _____

VI. Receiving Party - organization that will receive my information

Conseco, Inc. and its affiliated insurance companies (Conseco Insurance Company, Conseco Health Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company, Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company and Colonial Penn Life Insurance Company)

VII. Approval - Signed and dated by me or my legal representative

- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to: CONSECO CLAIMS DEPT– PO BOX 2024 – CARMEL, IN 46082-2024
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I am entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

* Legal Representatives provide documentation of legal authority

VIII. Return signed and dated form

Conseco Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

CCF07

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Phone: (800) 541-2254 Fax: (317) 208-8656

CANCER CLAIM FORM
PHYSICIAN'S STATEMENT

SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

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

Policy/Certificate Number: _____ Policyholder Name: _____

Patient Name: _____ Patient Date of Birth: _____

Hospitalization Information:

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Was patient confined to Intensive Care Unit? ☐Yes ☐ No

If more space is needed, please attach a copy of the standardized claim form (UB04, CMS1500, etc). Please include Intensive Care Unit detail if applicable.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state)	Was patient transferred from another facility?

Surgery/Anesthesia Information:

Did patient undergo surgery for this condition? ☐ Yes ☐ No If more space is needed, please attach acopy of a standardized claim form (UB04, CMS1500, etc.)

Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital

Name of facility: _____

Date of Service	Diagnosis/ICD Code	Surgery/CPT Code	Description of Surgery	Facility Name	Charges

Chemotherapy/Radiation Information:

Has patient received chemotherapy? ☐ Yes ☐ No If more space is needed, please attach a copy of the standardized claim form (UB04, CMS1500, etc).

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge	Facility	Diagnosis Code

Blood/Plasma Information:

Date Given	HCPCS/CPT Code	Number of units	Charges

(PHYSICIAN'S STATEMENT CONTINUED ON NEXT PAGE)

CCF09

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CANCER CLAIM FORM
PHYSICIAN'S STATEMENT

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

Policy/Certificate Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

1. Has patient been diagnosed with cancer? ☐ Yes ☐ No

Type of cancer: _____ ICD code: _____

2. Date of initial diagnosis: ____/____/____

Please provide the patient with a copy of the pathology report that diagnosed cancer, as it is required for all initial claims.

3. Patient first consulted you for this condition on: ____/____/____

4. Was the patient referred to you by another physician? ☐ Yes ☐ No

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

Please be sure to include the following information along with this claim form:

☐ **Positive Pathology Report** ☐ **Itemized bills from facility including diagnosis and/or procedure codes and charge amounts** **(Itemized bills may include but are not limited to the following claim forms: (UB04, CMS 1500, etc.)**

_____ _____ _____

Physician's Signature **Date** **Tax ID Number**

CCF010

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