

# State University of New York Medical Reimbursement Form Claims Incurred Outside of the United States



Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

**SEE REVERSE SIDE FOR REQUIRED AUTHORIZATION SIGNATURE AND INSTRUCTIONS**

| PATIENT INFORMATION  |  |   |                                   | INSURED INFORMATION (on ID Card) |                                |  |  |
|--|--|---|-----------------------------------|----------------------------------|--------------------------------|--|--|
| NAME: Family Name  |  | Given Name  |                                   | Certificate Number:              |                                | Group Name:<br>State University of New York (SUNY) |  |
| Birth Date<br>MM   DD   YY   |  | Gender  | Relationship to Insured member    |                                  |                                | NAME: Family Name Given Name                       |  |
|  |  | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Self     | <input type="checkbox"/> Son     | Reimbursement Mailing Address: |  |  |
|  |  | <input type="checkbox"/> Spouse                       | <input type="checkbox"/> Daughter |                                  |                                |  |  |
| Does The Patient Have Other Health Insurance Coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                                   |                                  |                                |  |  |
| Name of Other Health Insurance Company:  |  |   |                                   |                                  |                                |  |  |
| Policy Number  |  |   |                                   | Contact Phone Number:            |                                | Email Address:                                     |  |

**TO BE COMPLETED BY THE INSURED**

Please Describe your Accident or Sickness in the space provided below:

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Was this medical expense the result of a **motor vehicle accident**?  Yes  No

If YES, are you aware of any **pending legal action** relating to this accident?  Yes  No

Was this condition or injury the result of or caused by the patient's **participation in a sport**?  Yes  No

Was this medical expense the result of a **work related illness/injury**?  Yes  No

Have you been **treated for the same condition** within the last 24 months?  Yes  No

If yes, indicate date treatment began and date you were last treated: Began Treatment on: \_\_\_\_\_ Last Treatment Date: \_\_\_\_\_

**MEDICAL INFORMATION**

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

| Date of Service<br>(Mo/Day/Yr) | Provider of Service<br>(Name of Doctor, Lab, Ambulance Company, etc.) | Service Rendered<br>(Office Visit, X-ray, Prescription, etc.) | Illness or Diagnosis | Total<br>(Please Indicate Currency) |
|--------------------------------|---|---|----------------------|-------------------------------------|
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |
|                                |   |   |                      |                                     |

**GRAND TOTAL**

**PAYMENT INFORMATION**

|                                |   |
|--------------------------------|---|
| Payment Method:<br>(check one) | <input type="checkbox"/> <b>Check</b> (payable in US\$ and mailed to the address indicated above) <input type="checkbox"/> <b>Pay the Provider Directly</b> |
|--------------------------------|---|

## AUTHORIZATION

**Certification and Release of Information:** I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

For your protection, **California** requires the following to appear on this form: 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 a state prison.

In **Florida**, 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.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

**Applicants applying for accident and health insurance in New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Oklahoma, 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.

In **Kentucky and Pennsylvania**, 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.

In **Washington**, 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.

X \_\_\_\_\_  
Signature of Insured Member Date

## INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Normally, providers of health care will bill us directly for services to you and your enrolled dependents. This is the preferred procedure.

When your health care provider bills us, you do not need to send us a claim form. If a physician, ambulance company or other provider sends their bill directly to you, or if you paid for the services yourself and you want to be reimbursed, we have no way of knowing about your claim until we have received your bill at HTH Worldwide. This Member Claim Form was developed for you to notify us of any covered health services for which we have not already been billed.

Please read the following instructions about how to report health care services.

**Bills must be itemized:** Canceled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

**Each itemized bill must include:** Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), Name of patient, Date(s) of service, Amount charged for each service, Total Charge, Diagnosis or reason for treatment

**In addition, the following information must also be included on bills for the service types listed below:**

- **Outpatient Prescription Drugs:** Duplicate pharmacy generated receipt (not register tape) - must include Rx Number; Date Filled, Medication Name, Form, Strength and Quantity (NOTE: All Prescription Drug charges will be reimbursed to the insured person only)

SEND COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION TO:

**HTH Worldwide**  
International Claims Department  
One Radnor Corporate Center, Suite 100  
Radnor, PA 19087

**HTH Worldwide**  
Fax: 1.610.254.8794  
Email – [hthclaims@hthworldwide.com](mailto:hthclaims@hthworldwide.com)