

# Helpful Hints

*from specified disease claims department to guide you through filing your cancer, heart, stroke or accident claim with Conseco*

We value you as a policyholder 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 the claim process 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. hospital, medical, surgical, physician, anesthesia, etc.).
- Pathology reports must be submitted for all biopsies before benefits can be considered.
- For hospital stays, completed physician statements are required with a diagnosis for all inpatient confinements along with the corresponding itemized hospital bills 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.
- For nursing home care policies, please provide the nursing home certification, nurses licenses, and a physician statement.

## TOP 3 REASONS CLAIMS ARE DELAYED

1. Not including your *itemized bill*
2. Not including your *pathology report*
3. Not including your *procedure and/or diagnosis codes*

## WHERE TO SUBMIT CLAIMS

Mail all specified disease 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 the health call center, (800) 824-2726.

*Please note: Explanation of Benefits (EOBs) from another insurance company cannot be used to consider benefits. The original bills must be submitted.*



CONSECO.

Conseco Health Insurance Company
P. O. Box 2024 • Carmel, IN 46082-2024
Telephone 1-800-541-2254

CANCER, ALTERNATIVE CARE, INTENSIVE CARE AND HEART/STROKE CLAIM FORM

Please fill in the policy/certificate number(s) below that you are claiming benefits on:

Table with 4 columns: Cancer, Alternative Care, Intensive Care, Heart/Stroke. Each column has a 'No.' row for identification.

FILING INSTRUCTIONS

- Complete PART 1, PART 2 AND PART 6 of this claim form. Please complete using black ink.
Have your attending physician complete the part(s) of this claim form (only if new or changed diagnosis or hospitalized) that corresponds to the specific plan you are filing benefits under.

PART 3 - Cancer PART 4 - Intensive Care PART 5 - Heart/Stroke

Cancer claims - submit a copy of the pathology report that first diagnosed cancer. For subsequent surgeries, please submit the pathology report (if applicable) and operative report, along with corresponding bills.

\* Alternative Care claims - submit the itemized bills related to your cancer treatment.

Intensive Care claims - submit the itemized bill which shows the dates within Intensive Care. Any heart related claim or a condition for which you were treated within the last 12 months, past medical history and admit/discharge summaries may be required. (be sure to review the section of your policy/certificate which defines "Intensive Care Unit")

Heart/Stroke claims - submit the itemized bills and laboratory reports which treated and/or diagnosed Heart Disease, Heart Attack or Stroke.

- REMIT ALL BILLS, ALONG WITH THIS COMPLETED CLAIM FORM TO THE ABOVE ADDRESS
- Any incomplete portion of this claim form may result in a delay in processing your claim -

CONSECO RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION ON ANY CLAIM FOR DETERMINATION OF BENEFITS

PART 1 - POLICYOWNER/CERTIFICATE HOLDER INFORMATION

Policyowner/ Certificateholder \_\_\_\_\_ Phone Number \_\_\_\_\_
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_
Social Security # \_\_\_\_\_

Check Here IF new address

PART 2 - STATEMENT OF LOSS (to be completed by policyowner/certificateholder)

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sex  Male  Female Relationship to policyowner/certificate holder  Self  Spouse  Son  Daughter

Describe condition/sickness \_\_\_\_\_ Date of first treatment for this condition /sickness \_\_\_\_\_

Was this a result of an accident?  Yes  No If yes, please describe accident \_\_\_\_\_

If hospitalized, when? \_\_\_\_\_ Name and City of Hospital \_\_\_\_\_

List all physicians who have treated you for this condition. Include Name, Address & Phone Number.

Name Address Phone Number
\_\_\_\_\_
\_\_\_\_\_

**PART 3: CANCER PHYSICIAN STATEMENT** (to be completed by Physician's Office)

Physician Name (Specialty) \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**SECTION A: Cancer Claims (please attach copies of the pathology reports for all cancer surgeries, where applicable)**

Describe Condition: \_\_\_\_\_ Date of first treatment for this condition: \_\_\_\_\_

When was any type of cancer first diagnosed? \_\_\_\_\_ Type? \_\_\_\_\_

Is this patient's past medical history on file in your office? \_\_\_\_\_

Please indicate the name and address of the referring physician: \_\_\_\_\_

Was patient totally disabled due to cancer? \_\_\_\_\_ If yes, give dates of disability \_\_\_\_\_

**SECTION B: Hospital confinements**

Name of Hospital(s):	Hospitalization Date(s):	Diagnosis treated: (ICD - 9 codes)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Attach a copy of itemized bill(s) for services rendered to this patient.**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 4: INTENSIVE CARE PHYSICIAN STATEMENT** (to be completed by Physician's Office)

Physician Name (Specialty) \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Dates of Intensive Care Confinement:**

Name of Hospital(s):	Hospitalization Dates	Diagnosis treated: (ICD - 9 codes)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient ever had the same/similar condition? \_\_\_\_\_ If yes, please indicate the first date of treatment: \_\_\_\_\_

Has the patient ever been diagnosed or treated for a heart attack, heart condition, heart trouble, or any abnormality of the heart? \_\_\_\_\_

If yes, when and what type? \_\_\_\_\_

Was the confinement a direct result of an accident? \_\_\_\_\_ If yes, was it vehicular related? \_\_\_\_\_

Was the confinement alcohol or drug related? \_\_\_\_\_ If yes, please provide a copy of the laboratory results.

Is this patient's past medical history on file in your office? \_\_\_\_\_

Please indicate the name and address of the referring physician: \_\_\_\_\_

**Attach a copy of the itemized bill(s) for services rendered to this patient.**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 5: HEART/STROKE PHYSICIAN STATEMENT** (to be completed by Physician's Office)

Physician Name (Specialty) \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

Describe Condition: \_\_\_\_\_ Date of first treatment for this condition: \_\_\_\_\_

Has the patient ever been diagnosed or treated for any of the following conditions:

Condition	Yes	No	Date	Condition	Yes	No	Date
Heart Attack				Arteriosclerosis			
Heart Disease				High Blood Pressure			
Heart Abnormality				Stroke			
Disorder of Coronary Arteries				If Stroke, did stroke result in paralysis?			
Any other Heart Condition				Transient Ischemic Attack			
* type of Heart Condition							

Is this patient's past medical history on file in your office? \_\_\_\_\_

Please indicate the name and address of the referring physician: \_\_\_\_\_

Date(s) of Hospitalization:

Name of Hospital(s):	Hospitalization Dates	Diagnosis treated (ICD - 9 codes)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Attach a copy of the itemized bill(s) or laboratory reports for services rendered to this patient.**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART 6 - AUTHORIZATION**

I authorize any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to the particular company to which I am submitting a claim, or to its legal representative. I understand that the information obtained by use of this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Conseco to assist with this purpose.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid during the pendency of my claim and shall expire on the date my claim ends. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of authorization is as valid as the original.

Failure to sign this authorization may impair our ability to evaluate your health claim and may be a basis for denying a health claim for benefits. You have the right to revoke this authorization by notifying us in writing. Such revocation may be the basis for denying benefits.

**IMPORTANT**  
**PLEASE**  
**SIGN** ➔

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

**AK, DE 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.

**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, MN RESIDENTS:** Any person who knowingly and with intent to defraud or deceive an insurer 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 or deceive an insurer files a statement of claim containing 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.

**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.

**ME, TN, 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 may include imprisonment, fines or a denial of insurance benefits.

**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 RSA 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.

**NY 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 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.

**OH, 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 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.

**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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.