

# HOSPITALIZATION: PROOF OF LOSS - MEDICAL BENEFITS (HIP)



**STARMOUNT LIFE INSURANCE CO.**  
**7800 Office Park Boulevard**  
**Baton Rouge, LA 70809-7603**  
**1-888-729-5433, in Baton Rouge, 926-2888**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

## TO BE COMPLETED BY MAIN INSURED

Policy # \_\_\_\_\_

Name of Main Insured (Last Name) _____ (First Name) _____ (MI) _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____
Address of Main Insured (Street) _____ (City) _____ (State) _____ (Zip) _____			Soc. Sec. No. ____-____-____
Name of Patient _____		Age _____	Patient's Date of Birth ____/____/____
Patient's Soc. Sec. No. ____-____-____		Patient's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient's Occupation _____
		Receipt for amount paid must be attached. Done? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently using Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Child, Is She/He Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Child, Is She/He Older than 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of School _____

What caused the Hospitalization (complete description required)? _____	Name & Address of Hospital: _____	Dates of Hospitalization from: ____/____/____ to ____/____/____
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Has a previous claim been filed for this illness?  Yes  No

## AUTHORIZATION TO RELEASE INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, the Medical Information Bureau or other organization or person that has any records of me, my health, or any member of my family to give STARMOUNT LIFE or its reinsurers any such information. This includes knowledge about drug abuse, alcoholism or mental illness. Although information about drug or alcohol abuse may be protected by government regulation, I allow Starmount to collect it to determine insurability. 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 (in Ohio, is guilty of insurance fraud), (in Arkansas, is guilty of a crime and may be subject to fines and confinement in prison) or a felony of the third degree. In New Mexico, 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. This authorization is valid for the duration of the claim. A copy is as valid as the original.

Name of Patient _____	The foregoing information is correct and complete. Signature of Patient (Parent or Guardian If Claim Is On A Minor) _____	Date ____/____/____
I certify that the foregoing information is complete and correct. Signature of Main Insured _____	Your Home Phone ( ) _____	Your Work Phone ( ) _____
		Date ____/____/____

## TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

Diagnosis or Nature of Illness - Relate Diagnosis to Procedure In Column D by Reference to Numbers 1, 2, 3, etc. or ICD-9 Code 1. _____ 2. _____ 3. _____ 4. Was this caused by sickness or an accident?	Date First Consulted For This Condition ____/____/____	Hospitalization from ____/____/____ to ____/____/____	Did Patient have same or similar condition before? Yes ___ No ___
	Name and Address of Referring Physician _____		

A. Date of Service	B. Place of Service*	C. Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given	D. ICD-9 Diagnosis Code	E. Charges
____/____/____		Procedure Code: _____ (identify _____) (Explain unusual service or circumstances)		
____/____/____				
____/____/____				
____/____/____				

Your Patient's Acct. No. _____	Physician's or Provider's Tax Identification Number or Social Security Number To Be Used For Tax Reporting Tax ID # _____ Soc. Sec. # _____	Physician's or Provider's Name and Address: _____	Total Charge: _____ Amount Paid: _____ Balance Due: _____
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I certify the foregoing is true and correct and the charges are the actual charges to the insured. <b>Physician's or Provider's Signature:</b> _____	Date: ____/____/____	For office use only
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\* 1. (IH) - Inpatient Hospital    3. (O) - Doctor's Office    5. (PSY) - Day Care Facility    7. (NH) - Nursing Home    9. Ambulance    A. (IL) - Independent Laboratory  
 2. (OH) - Outpatient Hospital    4. (H) - Patient's Home    6. (PSY) - Night Care Facility    8. (SNF) - Skilled Nursing Facility    0. (OL) - Other Locations    B. Other Medical Facility

THE ISSUANCE OF THIS FORM IS NOT AN ADMISSION OF THE EXISTENCE OF ANY INSURANCE NOR DOES IT RECOGNIZE THE VALIDITY OF ANY CLAIM AND IS WITHOUT PREJUDICE TO STARMOUNT LIFE INSURANCE COMPANY'S LEGAL RIGHTS IN THE PREMISES