ASI

Association Services, Inc.

Specializing in Employer Group Health & Payroll Worksite Insurance Products

SAMPLE CLAIM LETTER

NAME
ADDRESS LINE 1
ADDRESS LINE 2

Reference to: GAP / Medical Reimbursement Claim

Enclosed is a American Fidelity claim form. **Please complete the form and return to**

ASI

28975 S Satsuma Road, Suite A

Livingston, LA 70754

Complete Claim form making sure to sign and date at the bottom. You must enclose a copy of the original itemized billings and explanation of benefits (EOBs) for each date of service. Please **make sure all information is complete before returning!** If you should have any questions, please give us a call. Thanks and have a blessed day!

Sincerely,

Association Services Staff

28975 S. Satsuma Road, Suite A
Livingston, LA 70754
(225) 435-0400 / 888-928-9222
Fax (225) 435-0403
www.asi-ins.com

American Fidelity Assurance Company
A member of the American Fidelity Group

REQUEST FOR MEDICAL REIMBURSEMENT

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

INSTRUCTION TO INSURED

1. Fully complete the claim form.
2. **For claim consideration** of physician office or clinic visit, please submit the itemized bills including diagnosis to the address or fax number above.
3. For **ALL** other charges, please submit itemized bills including diagnosis and the medical carriers' Explanation of Benefit sheet(s).

WARNING: 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 may be guilty of insurance fraud and subject to criminal and civil penalties.

INSURED INFORMATION

Insured's Name:	Insured's Date of Birth:	Insured's Social Security Number:
Address:	City:	State/Zip Code:
Insured's Customer Number:	Home Telephone Number:	Work Telephone Number:

PATIENT INFORMATION

Patient's Name:	Patient's Date of Birth:	Patient's Social Security Number:

Relationship To Insured: Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other ☐

If other was checked, please indicate relationship to insured:_____

CLAIM INFORMATION

1. What kind of claim is this? Physician Office or Clinic Visit ☐ Outpatient Care ☐ Inpatient Care ☐
2. Claim is due to: Illness ☐ Accident ☐ Pregnancy ☐
3. If illness, date of onset:_____ If pregnancy, date first diagnosed: _____

   Diagnosis/ICD9 code(s): _____
4. If accident, please explain how, when, and where it happened: _____
5. If claim is due to work related accident or sickness, please provide employer's name and phone number: _____

   Name: _____ Phone Number:_____

MEDICAL INFORMATION RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my or my dependents' medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits. *I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, AWD Benefits Department, P.O. Box 268898, Oklahoma City, Oklahoma 73126-8898 or calling toll free 1-800-437-1011. I understand that my right to revoke this authorization is limited to the extent that AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.*

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. **For Arizona residents,** release of HIV/AIDS - released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Print Name:_____ Signature:_____ Date:_____

Please retain a copy for your personal records, or you may request a copy from our company.