



Policy Number: _____

- 1. PLEASE FULLY COMPLETE THIS FORM
 - 2. ATTACH ITEMIZED BILLS (UB04 OR CMS HCFA1500 Bill)
 - 3. MAIL TO HSR
- E-mail: claims@hsri.com

8400 Belleview Drive, Suite 150
 Plano, Texas 75024
Payor ID# 65449
 Phone: (972)512-5600 Fax: (972) 512-5820
 Toll Free (800) 328-1114

- Plan: Sm&rt Med Premium
 Sm&rt Med Plus
 Sm&rt Med Value
 Sm&rt Med Basic

Underwritten by: United States Fire Insurance Company

Sm&rt Med Claim Form

POLICYHOLDER/ INSURED INFORMATION		
First Name	Middle	Last Name
Date of Birth (mm/dd/yyyy)		Member ID
Address		
City	State	Zip
Phone		Email
CLAIMANT/ PATIENT INFORMATION		
First Name	Middle	Last Name
Date of Birth (mm/dd/yyyy)		Member ID
Address		
City	State	Zip
Phone		Email
CLAIM INFORMATION		

- 1) Exact Nature of Injury or Illness: _____
 a. If Injury, description of Accident: _____

- 2) Date of Occurrence: _____/_____/_____
- 3) Is condition work related? Yes No
- 4) Is condition due to an auto accident? Yes No
 a. If Yes, Driver License #: _____ State: _____
 b. What type of Vehicle? _____
- 5) Type of Service Rendered: Hospital Admission Hospital Confinement Emergency Care for Sickness and/or Injury
 Inpatient Surgery Inpatient Surgery Anesthesia Outpatient Surgery Outpatient Surgery Anesthesia
 Wellness Office Visit Wellness Tests Ambulance Prescription Drug Outpatient Diagnostic Exam
 Outpatient X-Ray Outpatient Lab Test Therapy Services

Health Special Risk, Inc. (HSR) does not share private health information except as required or permitted by law. We are committed to guarding the private information entrusted to us.

I understand that 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. **By entering your name below, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form d value of the claim for each such violation.** New York Fraud Warning Notice: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material 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.

SIGNATURE _____ DATE _____

FRAUD WARNING NOTICES

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STATE SPECIFIC PROVISIONS

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
Alaska	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.
Arizona	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.
Arkansas	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
Louisiana	is guilty of a crime and may be subject to fines and confinement in prison.
California	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.
Colorado	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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware	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
Idaho	information is guilty of a felony.
District of Columbia	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.
Florida	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 of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Indiana	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.
Kentucky	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.
Maine	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 denial of insurance benefits.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Michigan	Any person who knowingly and with intent to defraud any insurance company or another 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 subject the person to criminal civil penalties.
North Dakota	
South Dakota	
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
New Hampshire	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.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
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.
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 material 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.
Ohio	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.
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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
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.
Rhode Island	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
West Virginia	is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee	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
Virginia	imprisonment, fines and denial of insurance benefits.
Washington	
Texas	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 state prison.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.



Policy Number: _____

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- E-mail: claims@hsri.com

Health Special Risk, Inc.
 8400 Belleview, Suite 150
 Plano, Texas 75024
 Payor ID# 65449
 Phone: (800) 328-1114 Fax: (972) 512-5820
 Underwritten by: United States Fire Insurance Company

Sm&rt Med Critical Illness Claim Form

1. Claimant's Name (Insured)	2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Claimant and Best Contact Phone Number (Include Area Code)				
7. If claim is on a dependent please complete the following: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner/ Civil Union <input type="checkbox"/> Child/Stepchild			8. Dependent's Name	
9. Dependent's Date of Birth	10. Dependent's Social Security Number	11. Dependent's Address if Different		

Critical Illness Information

Invasive Cancer: A malignant tumor, characterized by the uncontrolled growth and spread of malignant cells, invading tissue, blood or the lymphatic system.

Heart Attack (Myocardial Infarction): The death of a portion of the heart muscle (myocardium) due to a blockage of one or more of the coronary arteries and resulting in the loss of normal function of the heart.

Major Organ Transplant: Is the receipt by transplantation of:

- a. Human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation, or
- b. A whole human heart, lung, kidney, pancreas, or liver due to irreversible end state failure of such organ.

Stroke: An acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least thirty (30) days.

Other: _____

See your policy for complete benefits and exclusions

12. Describe condition or illness		
13. Date you were first seen for this condition	14. Confirmed diagnosis date	15. Have you ever been hospitalized for the same or similar condition <input type="checkbox"/> Yes <input type="checkbox"/> No
16. If Yes to question 15 provide name and address of hospital		
17. Reason for prior hospitalization		
18. Are you currently hospitalized for your current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. If yes to question 18 provide name and address of hospital		
20. Name and address of treating physician		

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21. Signature of claimant

22. Date

By entering your name above, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

In order to process your claim additional documentation may be required.
Medical records, pathology reports, office visit notes, EKG scans and/or various other records.
Please complete and return page 3 along with this claim form so we may request these documents on your behalf

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Authorization for Release of Medical Information

Patient Name _____

Date of Birth ____/____/____ Social Security # _____ - _____ - _____

I, _____ patient of _____ (physician name)
am authorizing Health Special Risk, Inc. to use and/or disclose my health information as identified below to:

Name of Provider _____

Address: _____

Phone Number _____

Fax Number _____

For the following purpose(s): Describe each purpose; if requested by the patient, you may state "at patient's request"

____ All Records from _____ (date) to _____ (date)

____ Initial Exam Records

____ All Office Records

____ All Hospital Records

____ Laboratory / Pathology Reports

____ Billing / Financial Statements

____ (Initials) I DO (____) or I DO NOT (____) consent to the release of information relating to psychiatric or psychological testing, alcohol and / or drug abuse diagnosis, prognosis and treatment and /or HIV (AIDS) testing and/or results.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid **180** days from the date signed unless a different expiration date, event or condition is specified. Specify: _____

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization.
3. A copy or facsimile of this authorization is as valid as the original.

Signature of Individual or Individual's Legal Representative

Date

Print Name or Print Name of Legal Representative

Relationship to Individual

Mail To: Health Special Risk, Inc
8400 Belleview Drive, Suite 150
Plano, Texas 75024

or

Fax to: 972-512-5820
Phone: 800-328-1114