



ASSOCIATION AND SOCIETY INSURANCE CORPORATION
P.O. Box 2510
Rockville, Maryland 20847-2510
1-800-638-2610 (Insured's Only)
301-816-0045 (All Others)

STATEMENT OF CLAIM AND AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS ON HOW TO SUBMIT A TRICARE CLAIM

1. The form must be completed by the Member and:
2. Page two must be completed by the claimant or claim delay may result.
3. Send the appropriate medical bills, hospital bills and all Explanation of Benefits worksheets from TRICARE to:
Claims Department, Group Insurance Administrator, P.O. Box 2510 Rockville, Maryland 20847-2510
4. TRICARE Prime claimants must submit a receipt from the provider of care showing the paid co-payment amount.

Assignment of Benefits

I hereby authorize payment of eligible benefits under my policy in connection with this injury or illness directly to (enter name of provider of care; hospital, doctor, etc.)

 Signature of patient or Guardian Relationship to Patient if signed by Guardian Date

Name of Member	Certificate Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married Other _____	Date of Birth
Address _____		City _____	State _____	Zip Code _____
Name of Association /Organization			Type of Claim <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Medical Indemnity <input type="checkbox"/> TRICARE	
Name of Patient	Address of Patient	Date of Birth	Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Nature of Accident or Illness – Describe			Have you claimed benefits for this condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes when?	
Provide Name and address of any Physician contacted for this condition.				
Name _____		Address _____		
Name _____		Address _____		

SECTION A - Health Information to be Used and /or Disclosed

Specify the health information to be released and /or used, including (if applicable), the time period(s) to which the information relates. Select only (1) of the following boxes:

- All my past, present or future health claims and/or medical records
- All of my health information relating to Claim number _____
- Other (please specify). _____

SECTION B – Person (s) Authorized to use and/or Receive Information

Specify the persons or class of person(s) authorized to use and/or receive the health information described in Section A:

SECTION C – Purposes for Which information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all the applicable boxes below.

- To facilitate the resolution of a claim.
- For a disability coverage determination
- At my request
- Other (please specify). _____

SECTION D – Expiration of Authorization

This authorization is valid until I terminate my coverage with this Plan, or, if specified

On the following date: _____

SECTION E – Your Rights

- You can revoke this Authorization at any time by submitting a written revocation to Association and Society Insurance Corporation P.O. Box 2510 Rockville Maryland 20847-2510.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and the information may no longer be protected by HIPAA.
- The Plan may not condition Treatment, payment, enrollment or eligibility for benefits on whether I sign the Authorization.
- I am entitled to a signed copy of this authorization.

By my signature below, I acknowledge that I have read, understood and agreed to the terms of this Authorization.

Signature of Patient or Guardian

Relationship to patient if signed by Guardian

Date

Signature of Legal Representative

(Attach legal documents as proof of representation)

Date

Please read the statement that applies to your residence and sign the bottom of the page.

For residents of 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.

For residents of all state EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon and Virginia: A person commits a fraudulent insurance act if that person knowingly and with intent to defraud any insurance company or other person, either (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of New Jersey, Arkansas, New Mexico and Louisiana: any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of 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 a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW 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 STATE PRISON.”

Signature

Date

LC-7363-0 10-30-03