How to file a Claim

Attached is a claim form for your insurance policy.
Please forward claims and questions to the following:

Mail to: Administrative Concepts, Inc
P.O. Box 4000
Collegeville, PA 19426-9000

Email: aciclaims@acitpa.com
Fax: 610-293-9299

For customer assistance, contact our service team at: **855-672-3231**

Step 1: Submit a completed Claim Form and return to ACI via email, mail or by facsimile.

- Fully complete the applicable sections of the form.
- **For Wellness Visits**, review your certificate of coverage for a complete list of services. Wellness Visits benefits for annual routine examination or well-child care visit. Covered Services include a history and physical, x-rays and laboratory testing such as a Pap test, colorectal screening, prostate cancer screening, mammography and bone density screening.
- Read the fraud warning statement
- Sign the form where indicated (bottom of page 2 of the claim form).

Step 2: Submit itemized medical bills and/or your explanation of benefits from your office visit.

- If you are submitting claims for multiple insureds, please include documentation from each wellness visit or hospitalization.

Notes: If we require additional information, a letter will be sent to you requesting the additional information. You should expect to receive a response within 7-10 days.

If you have questions or need to check the status of your claim, please contact us at: 855-672-3231

CHUBB

Underwritten by: ACE American Insurance Company

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426
Fax: 610-293-9299
Email: aciclaims@acitpa.com

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Employer Group Information:

Name of Employer / Group plan: **Salem Health Hospitals & Clinics**

Group policy number: **FXDN11132030**

Employee / Member Information:

Employee/Member Full Name _____

Member ID: _____ Date of Birth: _____

Address: _____ Apt/Unit #: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Note: If you do not know your **Member ID**, you may leave it blank or contact us at **855-672-3231** for assistance.

Claim Information (Hospitalization): *Use this form to file your Hospital Indemnity or Wellness Visit Benefit*

Hospitalization:

Patient First Name: _____ MI _____ Last Name: _____

Relationship to employee/member (ie Spouse, Child, Self etc): _____

Date of Birth: _____

Date of Hospitalization: _____

1) Reason for Confinement: _____

_____

_____

_____

2) Was type of room was your stay: **(check all that applies):** Semi or Private room: _____ ICU: _____ Observation: _____

a Semi or Private room: Hospital Admission Date: _____ Discharge Date: _____

b Intensive or Critical Care Unit: ICU/CCU Admission Date: _____ Discharge Date: _____

c Observation (outpatient): Observation Admission Date: _____ Discharge Date: _____

3) Name of Hospital: _____

City: _____ State: _____

Physician name: _____ Phone: _____

Claim Information (Wellness Visit): *If applicable. Check your plan documents for details.*

Wellness Visit: you may file a wellness visit claim for your spouse and/or covered dependents
(Please include a copy of the EOB or itemized bill from the preventive screening or well visit)

Insured Member Name: _____ **DOB:** _____

List the annual exam, screening or well-visit performed: _____

Date of visit: _____

Physician's Name: _____ Phone: _____

Medical Facility Name: _____

Address: _____

Insured Spouse Name: _____ **DOB:** _____

List the annual exam, screening or well-visit performed: _____

Date of visit: _____

Physician's Name: _____ Phone: _____

Medical Facility Name: _____

Address: _____

Insured Dependent Name: _____ **DOB:** _____

List the annual exam, screening or well-visit performed: _____

Date of visit: _____

Physician's Name: _____ Phone: _____

Medical Facility Name: _____

Address: _____

Insured Dependent Name: _____ **DOB:** _____

List the annual exam, screening or well-visit performed: _____

Date of visit: _____

Physician's Name: _____ Phone: _____

Medical Facility Name: _____

Address: _____

Administrative Concepts, Inc. does not share private health information except as required or permitted by law.
We are committed to guarding the private information entrusted to us.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Administrative Concepts, Inc. or the underwriting company. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

X_____ _____

Patient or Authorized Representatives Signature **Date**

IMPORTANT NOTICE

Notice of Alabama Claimants: 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.
Notice to Alaska Claimants: 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.
Notice to Arizona Claimants: 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.
Notice to Arkansas Claimants: 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.
Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Notice to Colorado Claimants: 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.
Notice to District of Columbia Claimants: 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.
Notice to Delaware Claimants: 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.
Notice to Florida Claimants WARNING: 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.
Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section.
Notice to Indiana Claimants: 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.
Notice to Kentucky Claimants: 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.
Notice of Louisiana Claimants: 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.
Notice to Maine Claimants: 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.
Notice to Maryland Claimants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Notice to Minnesota Claimants: A person who files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.
Notice to New Hampshire Claimants: 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.
Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Notice to New Mexico Claimants: 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.
Notice to New York Claimants Fraud Warning: 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 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.
Notice to Ohio Claimants: Any person who, with the 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.
Notice to Oklahoma Claimants: 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.
Notice to Oregon Claimants WARNING: Any person who, knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.
Notice to Pennsylvania Claimants Fraud Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or 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 subjects such person to criminal and civil penalties.
Notice to Rhode Island Claimants WARNING: 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.
Notice of Tennessee Claimants: 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 imprisonment, fines, and denial of insurance benefits.
Notice to Virginia Claimants: 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 imprisonment, fines and denial of insurance benefits.
Notice of Washington Claimants: 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 imprisonment, fines, and denial of insurance benefits.
Notice of West Virginia Claimants: 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.
Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

It is important to note that CHUBB North American Claims and the Accident & Health Division reserves its right to make changes to this language and may require additional fraud warnings incorporated onto the claim forms in the future.