TBR
Taylor Benefit Resource

Medical Bridge Claim Form

Please be sure to send the following information:

- **Medical Explanation of Benefits**
- **Diagnosis (ICD9) codes**
- **Signed and dated authorization**

****Please check the type of claim you are filing for below:**

- ☐ **Hospital Confinement**
- ☐ **Surgical Procedure**
- ☐ **Diagnostic Procedure**
- ☐ **Emergency Room**
- ☐ **Wellness**
- ☐ **Doctor's Office Visit**
- ☐ **Rehabilitation Benefit**

For q**uestions/concerns or to submit your claim:**
Taylor Benefit Resource
Toll Free: 888-352-5246
Phone: 229-225-9943
Fax: 229-225-9943
P.O. Box 6790
Thomasville, GA 31758

To be completed by Policy owner:

Claimant name Male Female	Birth Date	Claimant Social Security Number
Relationship to Policy Owner:		
Policy owner (First, Last)	Birth Date	Social Security Number
Mailing Address (Street or PO Box)		Apartment/Unit/Lot number
(City) (State) (Zip)		Home telephone number
Policy owner e-mail address		Work telephone number
Facility Name:		Facility Phone Number:
Facility Address:	Treating Doctors Name:	

Confinements:

Hospital: From: ___/___/____ to ___/___/____

Intensive Care Unit: ___/___/____ to ___/___/____

Rehabilitation: ___/___/____ to ___/___/____

If hospital confinement is for pregnancy or pregnancy complication please provide the date the pregnancy was diagnosed ___/___/____

Date of Deliver: ___/___/____ Type of Deliver ____ Vaginal ____ C-section

Surgical Procedure Date ___/___/____ **Procedure Description / Procedure Code:** _____

Diagnostic Procedure Date:___/___/____ **Procedure Description / Procedure Code:** _____

Date(s) of Doctor Office Visit(s): ___/___/____ ;___/___/____ ; ___/___/____ ; ___/___/____ ; ___/___/____

FRAUD NOTICE: Any person who knowingly files a statement of claim contacting false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form:

Policy Owner Signature: _____

Date: _____

***WELLNESS/HEALTH SCREENING**

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months, you'll need to submit the type and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number Write your name, address, social security number and/or policy/certificate number on your bill and indicate** "Wellness Test."

Type of Wellness Test Performed - Please complete one claim form for each claimant & for each calendar year.

- **You must attach a copy of the bill(s) for each test submitted.**
- **Please review your policy or policies for the list of covered tests prior to completing this form.**
- **The Health/Wellness Screening benefit is NOT payable for routine physical examinations.**
- **Most policies provide <u>one Health/Wellness benefit per calendar year</u>; (please refer to your policy for details.)**
- **<u>Please fill in the date for the test you had performed and attach a copy of the bill; the bill must include the Facility/doctor's name and telephone number</u>**

Test	Date
Blood Glucose	
Bone Marrow Testing	
Bone Marrow Testing	
CA125 (Ovarian Cancer)	
CA 15-3 (Breast Cancer)	
Cancer Vaccine	
Carotid Doppler	
CEA (Colon Cancer)	
Cholesterol (HDL/LDL/Lipids)	
Chest X-ray	
Colonoscopy	
Echocardiogram (Echo)	
Electrocardiogram (EKG/ECG)	
Hemocult Stool Analysis	
Mammogram (Breast)	
Pap Smear/Thin Prep Pap (GYN)	
PSA (Prostate)	
Serum Protein (Myeloma)	
Skin Biopsy	
Sigmoidoscopy	
Stress Test (Bicycle/Treadmill)	
Thermography	
Triglycerides	

Claim Fraud Statements

For your protection, the laws of several states, including **Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma,** and others require the following statement to appear on this claim form. **Fraud Warning :** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

Arizona Residents : 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.

California, Rhode Island, Texas and West Virginia Residents : For your protection, California, Rhode Island, Texas and West Virginia 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 Residents : 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.

District of Columbia: 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 Residents : 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.

Kentucky : For your protection, Kentucky law requires the following to appear on this form: 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, Tennessee, Virginia and Washington Residents : 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.

Maryland Residents : 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.

New Jersey and New Mexico : Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents : 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.

Pennsylvania Residents : 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

Oregon Residents : Any person who, knowingly and 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 that is relied upon by the insurer and is material to the content of the policy and to the risk assumed by the insurer, may be prosecuted for insurance fraud. There is no time limit on contestability in the event of fraud on the part of the insured.

Puerto Rico Residents : Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Authorization for Taylor Benefit Resource

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Taylor Benefit Resource and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Taylor Benefit Resource to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments. Any information Taylor Benefit Resource obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Taylor Benefit Resource will not re-disclose the information unless permitted or required by those laws. Re-disclosed information may no longer be protected by federal privacy laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Taylor Benefit Resource has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Taylor Benefit Resource may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Taylor Benefit Resource, Claims Department, P. O Box 6790 Thomasville, GA 31758

You may refuse to sign this form; however, Taylor Benefit Resource may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

X _____ XXX-XX-_____

(Signature) (Social Security Number — last 4 digits) (Date of Birth)

_____ _____

(Printed name of individual subject to this disclosure) (Date Signed)

If applicable, I signed on behalf of the insured as _____ (indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____ _____ _____

(Printed name of legal representative) (Signature of legal representative) (Date Signed)