HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, Indiana 46204
main 317 262 2132 web www.hccmis.com

CLAIMANT'S STATEMENT AND AUTHORIZATION

(See reverse side for Directions for Submitting a Claim)

HCC Medical Insurance Services
Box No. 2005
Farmington Hills, MI 48333-2005

PART A: Complete for all claims. **All Checks and Correspondence Will Be Sent To The Address Below**			
Insured Name:		Claimant (Patient) Name:	
Sex:	Birthdate:	Sex:	Birthdate:
Home Telephone:		Mailing Address (include Street Address, City, State, Country, and Postal Code):	
Work Telephone:			
Fax Number:			
E-mail address:			
Plan Number:		Certificate Number:	

1. Citizenship of Claimant: _____ Home Country of Claimant: _____
(Country where you principally reside & receive regular mail)

Country Visited: _____
(MNU may request a copy of your passport)

2. Is the Claimant: A full-time Student? ☐ Yes ☐ No If yes, please provide the name and address of school: _____

3. Is the Claimant: Employed? ☐ Yes ☐ No If yes, please provide the name and address of employer: _____

4. Do you or any family members have other coverage (medical, indemnity or liability) which might help cover hospital and medical expenses? ☐ Yes ☐ No If yes, please provide the following:

Name of Company:	Address:
Policyholder:	Policy Number:
Is this group insurance? ☐ Yes ☐ No	

PART B: Complete for new claims. If you need additional space, please attach additional sheets.

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning:

2. When did the first symptoms of this condition begin? State the exact date, if possible: (If due to an accident, please complete accident questionnaire, see Part C- DIRECTIONS)

3. Have you ever had or been treated for the same kind of illness or injury? ☐ Yes ☐ No If Yes, when? Name, address and telephone number of attending physician: _____

4. Name, address and telephone number of family physician (even if not consulted):

5. What ailments, diseases, illnesses, conditions or injuries have you had during the last five years? Please provide name and/or description of each condition, dates involved, and the name, address and telephone numbers of attending physicians:

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PART C: Complete for all claims.

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to HCC Medical Insurance Services. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	
Print Name:	Date:

Signature of Patient:	
Print Name:	Date:

DIRECTIONS FOR SUBMITTING A CLAIM

1. If this is a new claim, complete ALL PARTS of this form.
2. If this claim is a result of an accident, please visit www.hccmis.com "Downloads" to obtain the ACCIDENT QUESTIONNAIRE, or contact our office to request the form.
3. If this is a continuing claim, complete Parts A and C only.
4. Attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service.
5. Mail to: **HCC Medical Insurance Services**
   Box No. 2005
   Farmington Hills, MI 48333-2005
6. If you have any questions, call 1-800-605-2282. If calling from outside the US, call collect to (317) 262-2132.

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: 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.