CSEA
STATEMENT OF CLAIM FOR HOSPITAL & HOME CARE RECOVERY

INSTRUCTIONS:

You should complete and sign the Insured Statement. ***COMPLETION*** *of the entire form speeds claims processing.*
Please make sure that you sign the Authorization for Release of Information on page 4 of this claim form.
Have your provider of service complete the Attending Physician Statement on page 3 of this claim form.

MEMBER STATEMENT

MEMBER'S LAST NAME: FIRST NAME: INITIAL:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

(_____)_____-_____
DAYTIME TELEPHONE NUMBER

► DATE OF BIRTH:
MONTH____DAY____YEAR _____

► SEX: □MALE □FEMALE

► STATUS: □SINGLE □MARRIED
► □WIDOWED □DIVORCED

► SOCIAL SECURITY NUMBER: _____

PATIENT INFORMATION

LAST NAME: FIRST NAME: INITIAL:

STREET ADDRESS:

CITY: STATE: ZIP CODE:

► PATIENT SEX: □MALE □FEMALE

► DATE OF BIRTH:
MONTH_____DAY_____YEAR _____

► SOCIAL SECURITY NUMBER:
_____

Complete for Claim of Recovery Benefit(s).
Dates for which Recovery Care was needed: _____ _____ _____ _____

Please select Applicable Recovery Services Received:
□ Skilled Nursing Care provided by a registered Nurse (RN); Licensed Practical Nurse (LPN)
□ Home Health Aide Services □ Homemaker Services
□ Companion Services □ Speech, occupational or physical therapy

► NATURE OF SICKNESS OR INJURY:

► ON WHAT DATE DID SYMPTOMS FIRST APPEAR?
MONTH_____DAY_____YEAR _____

► ON WHAT DATE DID THE PATIENT FIRST CONSULT OR RECEIVE MEDICAL TREATMENT FROM A PHYSICIAN FOR THIS ILLNESS OR ACCIDENT?
MONTH_____DAY_____YEAR _____

► NAME AND ADDRESSES OF PHYSICIANS AND/OR MEDICAL FACILITIES TREATING THE PATIENT:

► NAME AND ADDRESS OF HOSPITAL WHERE CONFINED:

► DATES OF HOSPITAL CONFINEMENT:
FROM: _____ TO: _____
FROM: _____ TO: _____
FROM: _____ TO: _____

Please provide supporting documentation for care received. Attach a copy of hospital admission, discharge or bill for Home Care Services. If you are age 65 or over, please provide the Medicare Summary Notice or Home Health Plan of Treatment Statement. If you are less than age 65, please provide a copy of the Physicians Plan of Treatment Statement.

CONTINUE TO PAGE 2

MEMBER CERTIFICATION

I CERTIFY: ANY PERSON WHO KNOWINGLY AND WITH THE 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.

I HAVE READ AND UNDERSTAND THE FRAUD STATEMENT ON PAGES 5-6 FOR THE STATE IN WHICH I RESIDE.

New York Residents: Any person who knowingly and with the 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**.**

I CERTIFY THAT THE INFORMATION SHOWN ON PAGE 1 IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE:_ _____ Date:_____
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

MAIL COMPLETED FORM TO: PEARL CARROLL & ASSOCIATES
12 CORNELL ROAD, LATHAM, NY 12110, Office: (800) 697-2732 Fax: (518) 640-8105

CSEA
ATTENDING PHYSICIAN'S STATEMENT FOR HOSPITAL & HOME CARE RECOVERY

(The patient is responsible for the completion of this form without expense to the Company)

1. PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____
(First) (Middle) (Last) *(MM) (DD) (YYYY)*

MEMBER'S SOCIAL SECURITY NUMBER: _____

CURRENT MEDICAL CONDITION(s):

PRIMARY DIAGNOSIS: _____ ICD-10 CM CODE: _____

SECONDARY DIAGNOSIS: _____ ICD-10 CM CODE: _____

(If FRACTURE or DISLOCATION, describe Nature and Location): _____

2. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: ____/____/____
(MM) (DD) (YYYY)

DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: ____/____/____
(MM) (DD) (YYYY)

HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO
(If "Yes", state when and describe): _____

3. NATURE OF SURGICAL PROCEDURE, IF ANY: CPT CODE: _____

DATE PERFORMED: ____/____/____
(MM) (DD) (YYYY)

4. GIVE DATES OF SERVICES, IF ANY– **(From –To *Month/Day/Year)*:**

Office: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Home: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Hospital: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Nursing Home: ____/____/____ ____/____/____ ____/____/____ ____/____/____

5. IS THE PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? *(If "No" give date your services terminated)*

☐ YES ☐ NO Date: ____/____/____

6. HAS PATIENT BEEN TREATED FOR THIS ILLNESS/INJURY IN THE PAST 12 MONTHS? ☐ YES ☐ NO

If "YES" give treatment date(s): ____/____/____ ____/____/____ ____/____/____

IF PERFORMED IN HOSPITAL , GIVE NAME OF HOSPITAL. _____

☐ INPATIENT ☐ OUTPATIENT

MEDICAL PROVIDER'S DECLARATION AND SIGNATURE

PROVIDER'S NAME/SPECIALTY (PLEASE PRINT) | TAX ID/SOCIAL SECURITY # | TELEPHONE NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

PROVIDER'S SIGNATURE | DATE SIGNED

PLEASE MAIL COMPLETED FORM TO : PEARL CARROLL & ASSOCIATES, LLC
12 CORNELL ROAD LATHAM, NY 12110 Office: (800) 697-2732 Fax: (518) 640-8105

Authorization for Release of Information

Release from: _____

TO: All providers of medical services and supplies, pharmacy related service organizations, prescription history database suppliers, employers, insurance institutions, the Social Security Administration and other organizations.

I authorize release to New York Life Insurance Company or their representative, Pearl Carroll & Associates LLC, any independent claim administrators, consulting health professionals, pharmacy related service organizations and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV) and prescription records. This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying New York Life in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

_____ _____

Patient's Signature Date

_____ Social Security No.: _____

Print Name

_____

Address

_____

City State Zip Phone Number: _____

Email Address: _____

Release to: Datafied 1210 N. Jefferson St. Suite P, Anaheim, CA 92807

Please see that the completed form is returned to:

Pearl Carroll & Associates LLC
12 Cornell Road
Latham, NY 12110
Fax # 518-640-8105

STATE FRAUD STATEMENT

FOR ALABAMA RESIDENTS
"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."

FOR ALASKA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR 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 the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS
"Any person who knowingly presents a false or fraudulent claim for the 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."

FOR CALIFORNIA RESIDENTS "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."

FOR 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 claimant for the purpose of defrauding or attempting to defraud the 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."

FOR DELAWARE RESIDENTS
"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."

FOR DISTRICT OF COLUMBIA RESIDENTS
"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."

FOR FLORIDA RESIDENTS
"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS
"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."

FOR IDAHO RESIDENTS
"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."

FOR INDIANA RESIDENTS
"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."

FOR KENTUCKY RESIDENTS
"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."

FOR LOUISIANA RESIDENTS
"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."

FOR MAINE 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 include imprisonment, fines or denial of insurance benefits."

FOR MARYLAND RESIDENTS
"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."

FOR MINNESOTA RESIDENTS
"Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

FOR NEW HAMPSHIRE RESIDENTS
"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."

FOR NEW JERSEY RESIDENTS
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties in New Jersey."

FOR NEW MEXICO RESIDENTS
"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."

FOR OHIO RESIDENTS
"Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud."

FOR OKLAHOMA RESIDENTS
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."

FOR OREGON RESIDENTS
"Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals, for purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud."

FOR 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."

FOR PUERTO RICO RESIDENTS
"Any person who, knowingly, and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with the fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

FOR TENNESSEE 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 include imprisonment, fines and denial of insurance benefits.

FOR TEXAS RESIDENTS
"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."

FOR VERMONT 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."

FOR VIRGINIA 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 include imprisonment, fines or denial of insurance benefits."