



Hospital Indemnity/Outpatient Surgery Claim Form Instructions

EPIC's *Hospital Indemnity/Outpatient Surgery Claim Form* has three sections – Employee/Annuitant Information, Patient Information and Hospital Indemnity/Outpatient Surgery Information. Please complete all three sections and gather any necessary documentation immediately following your hospital discharge or outpatient surgery. Following these instructions will allow us to process your claim more efficiently.

Section I - Employee/Annuitant Information

This information pertains to the primary insured individual, whose name is in **bold** type on your EPIC ID card. Your Customer Number and Group-Division Number are also found on your EPIC ID card.

Section II - Patient Information

This information pertains to the covered Member who was confined in a hospital for more than two days or had an outpatient surgery.

Section III - Hospital Indemnity/Outpatient Surgery Information

This section is to be completed by the Patient's attending physician. As an alternative, you may attach an itemized bill for the charges incurred during the hospitalization or outpatient surgery.

Helpful Hints Regarding Your Claim

- Please make sure that all sections of the claim form are completed and that the Employee/Annuitant signs and dates the form before submitting it to EPIC. Incomplete claim forms will result in a claim denial.
- If you are attaching an itemized bill, please make sure that the bill captures all of the information we are requesting in Section III. If the itemized bill does not capture all of the requested information, please have the attending physician complete Section III.
- A Member must be confined in a hospital for more than two days to be eligible for the Hospital Indemnity Benefit. All claims filed for confinements that lasted two days or less will be denied.

Questions/Assistance

For questions or assistance, please contact EPIC's Claims Department at 800-520-5750 or claims@epiclif.com

Submitting Your Claim

Please ensure your claim form is fully completed, signed and dated. Please mail or fax your claim form and documentation to:

The EPIC Life Insurance Company
Attention: Hospital/Surgery Claims
P.O. Box 8430
Madison, WI 53708-8430

Fax: 608-223-2159 or 800-236-7610



Hospital Indemnity/Outpatient Surgery Claim Form

Employee/Annuitant Information

Name (First, Last, MI)

Date of Birth

Customer Number

Telephone

Group-Division Number

Street Address

City

State

Zip Code

Patient Information

Name (First, Last, MI)

Date of Birth

Gender

Male

Female

Relationship to Employee/Annuitant

Self

Spouse

Domestic Partner

Child

Other _____

Street Address

City

State

Zip Code

- Instead of having the attending physician complete the section below, I have attached an itemized bill that contains all of the requested information.

Hospital Indemnity/Outpatient Surgery Information

(To be completed by the attending physician)

Please check and provide date(s) for one of the following:

- The patient named above was confined in a hospital from _____ to _____
Admission date Discharge date

- The patient named above had an outpatient surgery performed on _____
Outpatient surgery date

Diagnosis/ICD-9 Code

Description of Surgery or Medical Services Received

Hospital or Surgery Facility Name

Telephone

Street Address

City

State

Zip Code

Attending Physician (please print)

Physician Signature

Date



For residents of Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin, West 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 a benefit under an insurance policy. **A fraudulent insurance act is a crime.** EPIC shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 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.

The information on this form is true, complete and accurate to the best of my knowledge and belief.

Name of Employee/Annuitant (please print)

Signature of Employee/Annuitant

Date

Please mail or fax this form to:

**The EPIC Life Insurance Company
Attention: Hospital/Surgery Claims
P.O. Box 8430
Madison, WI 53708-8430**

Fax: 608-223-2159 or 800-236-7610