SelmanCo

P.O. Box 2510
Rockville, Maryland 20847-2510
1-800-638-2610

Underwritten by Transamerica Financial Life Insurance Company

TRICARE/CHAMPVA SUPPLEMENT STATEMENT OF CLAIM AND AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS ON HOW TO SUBMIT A TRICARE/CHAMPVA SUPPLEMENT CLAIM

1. The form must be completed by the Member and:
2. Page two must be completed by the claimant or claim delay may result.
3. Send the appropriate medical bills, hospital bills and all Explanation of Benefits worksheets from TRICARE/CHAMPVA to: Claims Department, Group Insurance Administrator, P.O. Box 2510 Rockville, Maryland 20847-2510
4. TRICARE Prime claimants must submit a receipt from the provider of care showing the paid co-payment amount.

Assignment of Benefits: I hereby authorize payment of eligible benefits under my policy in connection with this injury or illness to:

Name of Provider of Care (Doctor, Hospital, etc.) _____

_____ _____ _____
Signature of Patient or Guardian | Relationship to Patient if Signed by Guardian | Date

Name of Member		Member ID#	Sex ☐ Male ☐ Female
Date of Birth	Social Security Number	Marital Status ☐ Single ☐ Married ☐ Other_____	
Address (Street, City, State & Zip Code)			
Name of Association/Organization/Credit Union/Employer		Type of Claim: ☐ TRICARE Prime ☐ TRICARE Standard ☐ CHAMPVA	
Name of Patient		Relationship to Member ☐ Spouse ☐ Daughter ☐ Son ☐ Other	Date of Birth
Address of Patient (Street, City, State & Zip Code)			
Nature of Accident or Illness - Describe		Have you claimed benefits for this condition previously? ☐ No ☐ Yes If Yes, when? _____	

Provide Name and address of any Physician contacted for this condition.

Name _____ Address _____

Name _____ Address _____

SECTION A - Health Information to be Used and or Disclosed
Specify the health information to be released and or used, including (if applicable), the time period(s) to which the information relates. Select only (1) of the following boxes:

☐ All my past, present or future health claims and/or medical records

☐ All of my health information relating to Claim number

☐ Other (please specify). _____

SECTION B - Person (s) Authorized to use and/or Receive Information
Specify the persons or class of person(s) authorized to use and/or receive the health information described in Section A:

SECTION C - Purposes for Which information will be Used or Disclosed
Specify each purpose for which the health information described in Section A may be used or disclosed. Select all the applicable boxes below.

☐ To facilitate the resolution of a claim

☐ For a disability coverage determination

☐ At my request

☐ Other (please specify). _____

SECTION D - Expiration of Authorization
This authorization is valid until I terminate my coverage with this Plan, OR, if specified

☐ On the following date: _____

SECTION E - Your Rights

- You can revoke this Authorization at any time by submitting a written revocation to Selman & Company, P.O. Box 2510, Rockville, Maryland 20847-2510.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information may no longer be protected by HIPAA.
- The Plan may not condition Treatment, payment, enrollment, or eligibility for benefits on whether I sign the Authorization.
- I am entitled to a signed copy of this Authorization.

By my signature below, I acknowledge that I have read, understood and agreed to the terms of this Authorization.

_____	_____	_____
Signature of Patient or Guardian	Relationship to Patient if Signed by Guardian	Date

_____	_____
Signature of Legal Representative	Date

(Attach legal documents as proof of representation)

FRAUD WARNING NOTICES

Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.

Alabama: 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.

Alaska, Minnesota, New Hampshire: 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.

Arkansas, Louisiana, New Mexico, Texas, West Virginia: 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.

Arizona: 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: For your protection California 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: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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.

Maine, Virginia, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company 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.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234.

District of Columbia: 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.

Oklahoma: 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.

Kentucky, 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 such person to criminal and civil penalties.

Maryland: 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: 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 violation.

Ohio: Any person who, 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 is guilty of insurance fraud.

Oregon: Any person who knowingly and with intent to defraud, files a claim for benefits may be guilty of insurance fraud and may be subject to prosecution.