Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

STATEMENT OF CLAIM
HSA HOSPITAL INDEMNITY RIDER

Mail Claim Form to:
Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650

Instructions:
1. **Please make sure all questions on Insured's statement are completed in full.**
2. **Submit ONLY for hospital confinements lasting 3 days or more.**
3. **Submit HSA Blue PPO or HSA Blue PPO Plus Insurance Policy Explanation of Benefits for the hospital confinement. (Required)**
4. **Authorization must be signed and currently dated.**

INSURED'S STATEMENT

Insured's Name (First, Last)		Policy Number (Required)	
Home Address (City, State, Zip)		Telephone Numbers Work ( ) Home ( )	
Patient Name (First, Last)	Patient's SSN	Date of Birth	Relationship to Insured
Date of Hospital Admission		# of Days Confined	
Name of Hospital			
Hospital Address (City, State, Zip)			

Limit one claim per Covered Person and two claims per family.

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to Arkansas Blue Cross and Blue Shield (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request.

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.

Date: _____ **Signature of Patient:** _____