

# Instructions for Filing Claim for Employee Reimbursement

To expedite the handling of your claim, please follow the instructions listed below. Incomplete forms will be returned to you unprocessed. We are committed to providing the best service that protects you and which is also compatible with the current insurance industry standards. If you have any questions concerning your benefits or your claims, please call 800-635-6585.

1. Each covered claimant must submit a completed form.
2. Original bills should be submitted.
3. Obtain an itemized bill for each claimant.
  - a. In accordance to HIPAA guidelines the format of the bill we receive must include all of the appropriate service codes/modifiers, diagnosis codes, provider name, address and Tax Identification Number to facilitate necessary reporting. A standardized bill would be a 1500 (CMS) form for physicians and a UB92 form for hospital or institutional charges. These bills can be obtained from your provider.
  - b. Or, you may also submit an itemized bill from your doctor that contains the following: dates of treatment, description of services, service codes/modifiers, diagnosis codes, specific charges, and the nature of the illness or injury.
  - c. **A UB92 form is always required for hospital services.**

Mail your completed claim form and itemized bills to:  
**Nationwide Specialty Health**  
**PO Box 420**  
**Springfield, MA 01101**

Figure 1: CMS 1500 Form

Figure 2: UB92 Form

## Nationwide Life Insurance Company will review the form for completeness:

- Has Nationwide received all of the appropriate medical documentation?
- Does Nationwide need additional information?
- Are the premiums paid current by the group?
- Is the benefit eligible under the plan?
- Is the date of service within the eligibility period under the plan?
- Have accident details been submitted to Nationwide?

If all information is received, Nationwide Life Insurance Company will process the claim within 30 days. An Explanation of Benefits, which may include a check if payment for eligible expenses is rendered, are issued weekly and mailed via first class mail within 24 hours of printing.

## State Fraud Notices

**(LA)** 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.

**(MO)** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

**(PA)** 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.

**(PR)** 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 a fine of 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 aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

**(WA)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

**(All Other States)** 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/or civil penalties.

# Insured Reimbursement Medical Claim Form

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Print Legibly



**Nationwide**  
On Your Side

Employer's Name:	Group No:
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## Employee and Claimant Information

Employee's Last Name:	First Name:	Middle:	Employee's Birth Date:	Member Number: (shown on id card)
			/ /	

Claimant's Last Name:	First Name:	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Claimant's Birth Date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			/ /	

Home Address:	PO Box:

City:	State:	Zip:	Home phone #:
			( )

If the Claimant is a dependent child over age 19 and a full-time student, provide the name and address of the school they are attending. Proof of full-time student status for the period of medical expenses in the form of a letter from the school or a transcript is required before the claim can be processed.

Name of school:	Address:
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City, State and Zip:
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## Accident Information, if applicable (If the claim is a result of an accident, supply details of the accident.)

<b>Date and Time of Accident:</b> Date ___/___/___ Time _____ AM or PM	<b>WHAT</b> injuries were received?
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<b>WHERE</b> did the accident take place?
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<b>HOW</b> did the accident take place? (Be specific and explain exactly what happened)
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<b>Is the accident/injury related to work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the claim for Accidental Death or Dismemberment benefit?</b> If yes, check one: <input type="checkbox"/> Dismemberment <input type="checkbox"/> Fatality
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## PLEASE READ AND SIGN BELOW

I request my insurance benefits be paid directly to the insured employee. I understand that I am financially responsible for any balance to the provider.

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to give NATIONWIDE INSURANCE, Columbus Ohio, or its legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Whomever in any document required by the title of the employee retirement income security act of 1974 makes any false statement or representation of fact shall be fined not more than \$10,000 or imprisoned not more than five years, or both.

Employee's signature	Date
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Spouse's signature (If the claim is for the spouse, both must sign)	Date
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