# HOSPITAL INDEMNITY
## CLAIMS FORM

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Please review your policy for specific benefits covered under your plan.
To prevent processing delays, please have claim form completed in full and return the signed HIPPA.

Please submit medical documentation from your healthcare provider to support your claim.

Email completed forms to claims@breckpoint.com

| AUTHORIZATION |
|---|
| I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form. |
| Insured's signature: _____ Date: _____ |
| Patient's signature: _____ Date: _____ |

| HOSPITAL INDEMNITY CLAIMS FORM | | | |
|---|---|---|---|
| Employer's Name: | Insured's Email: | | |
| Insured's Medical Insurance Provider: | Insured Medical ID #: | | |
| Insured's Name: | Social Security Number: | Date of Birth: | Gender: |
| Insured's Address, City, State, Zip: | | | |
| Patient's Name (person who is sick or injured): | Date of Birth: | Gender: | Insured's Phone #: |
| **By providing your email address above, you consent to the use of electronic transactions in connection with your Breckpoint policies, contracts, and/or account to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that Breckpoint may be legally required to deliver to you).* | | | |

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**Please sign the attached HIPPA form and return with completed claim form.**
****If filing a claim within the first policy year for benefits, medical records may be requested****

| | |
|---|---|
| Is medical treatment due to an injury?<br>(If yes, provide the date of the injury): | ☐ YES ☐ NO |
| Describe how the injury occurred: | |
| Location of the injury: | ☐ On the Job ☐ Off the Job |
| Was the patient in a motor vehicle accident?<br>(If yes, attach a copy of the Police Report.) | ☐ YES ☐ NO |
| Is treatment related to an illness?<br>(If yes, complete the following questions related to illness.) | ☐ YES ☐ NO |

| What is the illness diagnosis? | When did symptoms first occur? | What is the first date of treatment for the illness? |
|---|---|---|
| | | |

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|---|
| If diagnosed with cancer, what is the date of the initial diagnosis?<br>(Attach a copy of the pathology report.) |
| Was the patient treated by other physicians for this illness or a related condition?<br>(If yes, provide the physician's information below.) ☐ YES ☐ NO |

| Treatment Date | Physician's Name | Address, City, State, Zip | Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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**PREGNANCY CLAIMS**

| Date of Delivery: | If not delivered, expected delivery date: |
|---|---|

| |
|---|
| List any complications related to your pregnancy: |

5130 South Fort Apache #215-365, Las Vegas, NV 89148 ◂ (844) 798-4878 ◂ claims@breckpoint.com
To review claims status and verify eligibility please visit your Claims Member Portal. portal.breckpoint.com

# HOSPITAL INDEMNITY
## CLAIMS FORM

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| Complete the remaining sections for ALL claims | | | |
|---|---|---|---|
| Patient's primary treating physician: | | | |
| Physician Name: | Address, City, State, Zip | | Phone: |
| Was the patient confined to the hospital as a result of this condition? (If, yes please submit a copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital.) | | | ☐ YES ☐ NO |
| Hospital / Facility Name: | Phone: | Admission Date: | Discharge Date: |

| Hospital / ICU Admission & Confinement Benefit | | | |
|---|---|---|---|
| Where patient was admitted, confinement or received treatment: | | | |
| Hospital Name: | Address, City, State, Zip: | | |
| Phone: | | Tax ID Number: | |
| Is this facility also your place of employment? | | | ☐ YES ☐ NO |
| Was the patient confined to the intensive care unit as a result of this condition? (If yes, submit copy of a UB-04 billing invoice from the hospital facility to identify the days spent in the intensive care unit.) | | | ☐ YES ☐ NO |
| Was the patient treated in an emergency room as a result of this condition? (If yes, submit emergency room admission and discharge papers.) | | | ☐ YES ☐ NO |

| Mental / Nervous Disorder & Substance Abuse Hospital / Residential Treatment Facility Benefit | | | |
|---|---|---|---|
| Was the patient admitted, confined or received treatment at a Hospital or Residential Treatment Facility? (If yes, attach a copy of room charge at either residential or hospital facility) | | | ☐ YES ☐ NO |
| Facility Name: | Address, City, State, Zip: | | |
| Phone: | | Tax ID Number: | |
| Is this facility also your place of employment? | | | ☐ YES ☐ NO |
| Was the patient confined to the intensive care unit as a result of this condition? (If yes, submit copy of a UB-04 billing invoice from the hospital facility to identify the days spent in the intensive care unit.) | | | ☐ YES ☐ NO |
| Was the patient treated in an emergency room as a result of this condition? (If yes, submit emergency room admission and discharge papers.) | | | ☐ YES ☐ NO |

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# HIPPA AUTHORIZATION
## TO OBTAIN INFORMATION

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LEAD TOGETHER

**Send to:**

Breckpoint Inc.
5130 South Fort Apache
#215-365
Las Vegas, NV 89148

**Phone:** (844) 789-4878
**Email:** claims@breckpoint.com

| | | | |
|---|---|---|---|
| Primary Certificate Holder: | SSN (Optional): | Date of Birth: | |
| Certificate Number(s): | | | |
| Address: | City: | State: | Zip code: |
| Name of Individual Subject to Disclosure (If not the Primary Certificate Holder): | | Date of Birth: | |
| Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild | | | |

**I. Authorization:**
For the purpose of evaluating my eligibility for insurance and for benefits under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information (defined below) about me and, if applicable, my dependents, from the sources listed below to Breckpoint, or any person or entity acting on its part.

**II. Disclosure of Health Information:**
Health information may be disclosed by any health care provider, health plan (including Breckpoint or additional coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psycho-therapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Breckpoint will not disclose the information unless permitted or required by those laws.

**III. Rights and Expiration:**
I understand that I may revoke this authorization at any time, except to the extent that Breckpoint has taken action in reliance on this authorization. If I revoke this authorization, Breckpoint may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to Breckpoint at the address above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

**IV. Notice:**
I understand that Breckpoint is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
• If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form
• If records are on a minor child the natural parent or legal guardian must sign on their behalf.

_____ _____
Signature of Individual Subject to Disclosure | Date Signed:

_____ _____ _____ _____
Legal Representative's Printed Name | Legal Representative's Signature | Legal Relationship | Date

***If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)***