Consultation Benefit Claim Form

Please check your policy for the benefit eligibility or call Sterling Customer Service at 1-866-459-1755 for help.

- Please use blue or black ink only and print legibly when completing the form in its entirety.
- Please submit proof of service, by either Explanation of Benefits or receipt of service (receipt of service may include, but is not limited to the following claim forms: UB04, CMS 1500, etc.)
- Please read the Claims Fraud Warning Statement for your state of residence, found after Claim form.
- Please complete the required documentation: Authorization to Obtain Medical Records form, Claim form, and supporting proof of service documents.
- Sign, date, and mail the completed forms to the Sterling Insurance address shown below or fax to 1-877-826-6237.
- Please keep a copy of this completed form and a copy of the supporting document for your records.

Please keep in mind, failure to send all completed and required forms at time of submission may delay the processing of this claim.
## Consultation Benefit Claim Form

### Policyholder Information

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policyholder’s First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Policyholder’s Address</th>
<th>City</th>
<th>ST</th>
<th>Zip</th>
<th>Phone Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Patient’s First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Relationship to Policyholder:</th>
<th>Gender</th>
<th>M</th>
<th>F</th>
<th>Patient’s Date of Birth</th>
</tr>
</thead>
</table>

Please provide the names, addresses and phone numbers of primary physician and consulting physician:

### Physician Information (Use separate sheet if needed)

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Address</th>
<th>City</th>
<th>ST</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

I certify, by signing my name on this document, I declare that all information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of executing this form.

**Patient’s Signature (or legal representative)**

X

Today’s Date M M D D Y Y Y

**Policyholder’s Signature**

X

Today’s Date M M D D Y Y Y
Physician Statement Consultation Benefit Claim Form

To be filled out by the consulting Physician.
Failure to complete all sections may delay the processing of this claim.

Policy Number

Policyholder’s First Name | MI | Last Name

Patient’s First Name | MI | Last Name

Patient’s Date of Birth

Physician’s First Name | Last Name

Address

City

ST Zip Phone Number

Fax Number

NPI Number

Consultation Benefit
Consultation Date

Please indicate covered specified critical condition that the Patient consulted you for a treatment plan:
Please note events listed may not be covered by the Patient’s Policy.
Please have the Patient check their Policy for a list of covered events and tests or call 1-866-459-1755.

☐ Heart Attack (Myocardial Infarction) Physician’s Initials ______

☐ Kidney Failure Physician’s Initials ______

☐ Major Organ Transplant Physician’s Initials ______

☐ Paralysis Physician’s Initials ______

☐ Severe Burns Physician’s Initials ______

☐ Stroke Physician’s Initials ______

☐ Benign Brain Tumor Physician’s Initials ______

☐ Blindness Physician’s Initials ______

☐ Loss of Hearing Physician’s Initials ______

☐ Loss of Speech Physician’s Initials ______

☐ Cancer Physician’s Initials ______

Physician’s Signature

X ____________________________

Today’s Date

MM DD YYYY
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.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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.

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

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of a claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is subject to criminal and civil penalties.

Indiana: A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person, who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits and application or files a claim containing a false or deceptive statement may be guilty.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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.

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.

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 false, incomplete or misleading information is guilty of a felony.

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.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a 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.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim are provided by the claimant.
Important information about this Authorization to Obtain Medical Records

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment or the terms of my insurance coverage, but may prevent my insurance company from being able to determine when benefits are payable in the event of a filed claim.
- I understand that I can revoke this Authorization at any time, except to the extent it has been relied upon, by sending a written revocation to the address below.
- I understand if the person or organization that I authorize to receive information described in this Authorization is not subject to federal health information privacy laws then such information could be re-disclosed and would no longer be protected by these laws.
- I understand that I have a right to receive a copy of this Authorization.
- I understand that a photocopy or facsimile of this Authorization is as valid as the original.

Policyholder Information

Policyholder’s First Name ___________________________ MI ___________________________ Last Name ___________________________

Policyholder’s Address ____________________________________________________________

ST Zip Phone Number ___________________________ Social Security Number ____________

Date of Birth ___________ ___________ ___________ Policy Number _______________________

Patient Information

Patient’s First Name ___________________________ MI ___________________________ Last Name ___________________________

Relationship to Policyholder: [ ] Policyholder [ ] Spouse [ ] Dependent Child [ ] Is patient deceased? [ ] Yes [ ] No

Policyholder’s Address ____________________________________________________________

ST Zip Phone Number ___________________________ Social Security Number ____________

Gender [ ] M [ ] F Patient’s Date of Birth ___________ ___________ ___________ ___________ ___________ 

Authorization to Release Medical Information

I authorize US Department of Health and Human Services (including Centers for Medicare and Medicaid Services and any contractors or agents), any physician, medical professional, hospital, clinic, pharmacy related services organization, health plan, or insurance company to disclose to Sterling or its reinsurers medical records, prescription records, or other such information upon presentation of this authorization or reproduction thereof. I understand the purpose of this disclosure and use of my information is to determine the amount payable for my claims. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for no longer than twelve (12) months and may be revoked by sending written notice to Sterling. This authorization is a condition of your eligibility for benefits.

Patient’s Signature (or legal representative) ___________________________ Today’s Date ___________ ___________ ___________ ___________ 

Policyholder’s Signature ___________________________ Today’s Date ___________ ___________ ___________ ___________