Wellness Screening Benefit Claim Form

Please note that some tests listed on this claim form may not be covered under your policy. Please check your policy for the covered tests under your Wellness Benefit 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.
Wellness Screening Benefit Claim Form

**Policyholder Information**

Policy Number

Policyholder’s First Name

MI Last Name

Policyholder’s Address

City

ST Zip Phone Number Date of Birth

**Patient Information**

Patient’s First Name

MI Last Name

Relationship to Policyholder: Policyholder Spouse Dependent Child

Gender M F Patient’s Date of Birth

**Wellness Screening Benefit**

Test Treatment Date

Check the Wellness Screening Test:

- Blood Test for Triglycerides
- Biopsy
- Breast Ultrasound
- Breast MRI
- Carotid Doppler
- CA15-3 (blood test for breast cancer)
- CA 125 9 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-Ray
- Colonoscopy
- Echocardiogram
- Electrocardiogram (EKG)
- Fasting Glucose Test
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammogram
- MRI Scan of Organs
- Neurological Examination (brain tumor)
- PSA (Blood test for Prostate Cancer)
- Serum Cholesterol Test
- Stress Test on Bicycle or Treadmill
- Testicular Ultrasound
- Thermography
- Pap Smear
- ThinPrep
- Ultrasound of Organs
- Virtual Colonoscopy

**Physician Information**

Please include physician name, address, phone number who ordered/administered the test.

First Name

MI Last Name

Address

City

ST Zip Phone Number

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

**Policyholder’s Signature**

X Today’s Date
**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 state 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 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 guilty of a felony.

**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   M M D D Y Y Y Y   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   M M D D Y Y Y Y

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)  

X  Today’s Date   M M D D Y Y

Policyholder’s Signature

X  Today’s Date   M M D D Y Y