MetLife

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

CoreSource
P.O. Box 25946, Overland Park, KS, 66225-5946
Toll Free (Within U.S.): 1-866-217-5631 Fax: 1-913-387-5951
Usa.metlifeexpat@metlife.com

**If you are a New York Resident:** 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

# UNITED STATES CLAIM FORM

To be used by employees for services rendered inside the United States
Medical, Dental and Vision

Please mail, fax, or email this signed completed form with itemized bills and receipts to the address or fax number listed above. Please tape small receipts on 8.5 X 11 inch paper. Please do not staple receipts to claim form. If already enrolled with direct deposit, we will automatically send payment to your account.

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia**: 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.
**Alaska**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.
**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. **California**: For your protection, California law requires the following to appear on this form: 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.
**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, Idaho, Indiana and 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 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 insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
**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.
**Maine, Tennessee and 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 may include imprisonment, fines or a denial of insurance benefits.
**Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
**New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20
**New Jersey**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
**Oregon**: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.
**Puerto Rico**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
**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.
**Vermont**: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.
**Virginia**: Any person who, with the 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 may have violated the state law.
**Pennsylvania and 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 civil penalties.

## Claim Filing Instructions

Part A: Employee Information: This section must be answered fully and clearly to establish positive identification of your eligibility. This enables us to have accurate and current mailing information for the proper mailing of your benefit check or information.

Part B: Answer this portion in detail if the claim is for a dependent. Please respond to the last inquiry in this section, if applicable, for both employee and dependent claims.

Part C: Please include a reason (chief complaint) for the treatment or the diagnosis provided by the physician in this section if confidentiality laws prohibit the provider from entering a diagnosis on the bill or if that bill is written in a language other than English.

Part D: Complete this section to indicate your desire for a check or direct deposit of funds. If you do not indicate a preference, and direct deposit form has been completed, reimbursement will be sent based on the completed form. If you have not indicated a preference, and a direct deposit form has not been completed, a check will automatically be sent. If you prefer payment to be made directly to the provider (contingent upon provider accepting assignment), please sign where indicated.

Part E: This section must be signed by the patient and also the employee if the employee and patient are not the same person. (If the patient is a minor child, he/she, the authorized representative, should sign the form).

## Part A

Employee's Name: Employer Information:

| First | Middle | Last | Employer Name | Group Policy Number |
|---|---|---|---|---|
| Mailing Address: | | | E-mail: | |
| City | State | Postal Code | Country | Birth Date |
| Is this a permanent change of address? ☐ Yes ☐ No | | Employee status: ☐ Active ☐ Retired ☐ Disabled ☐ Deceased | | |

## Part B

Patient's Name: Patient's Gender: Relationship to Employee:

| First | Middle | Last | Birth Date | ☐ Male ☐ Female | ☐ Self ☐ Child | ☐ Spouse ☐ Other |
|---|---|---|---|---|---|---|
| Does your family have any other form of medical or dental coverage? If so, please provide details so that we may coordinate coverage. ☐ Yes ☐ No | | | Details: | | | |

## Part C

| |
|---|
| Diagnosis or Chief Complaint: |
| Is condition due to an injury or accident arising out of patient's employment? ☐ Yes ☐ No |

## Part D

| Payment to Employee: Please indicate where the payment should be sent. | AUTHORIZATION TO PAY PROVIDER (Contingent upon provider accepting assignment) |
|---|---|
| ☐ Check (payment to address as listed above) *USD Only | ☐ Make payment directly to provider (please sign below) |
| ☐ Direct Deposit (if not already enrolled, please complete the direct deposit form below) *US Banks & USD Only | |
| | Employee's Signature Date |

## Part E

**AUTHORIZATION TO RELEASE, OBTAIN AND PROCESS PERSONAL INFORMATION**

I authorize any personal information, including sensitive information (such as health information) and financial information, relating to this claim to be disclosed to and acquired and processed by Delaware American Life Insurance Company ("DelAm") and its affiliates and agents, including CoreSource, Inc. Such information will be used for the purpose of processing, administering, evaluating and adjudicating claims, utilization review, financial audit and to service and provide insurance benefits. This authorization includes any transfer of personal information, including sensitive information, for the purposes described above from outside the United States, including the European Economic Area and other jurisdictions with similar data privacy regimes, into the United States or other jurisdictions that may not be considered to have an adequate level of data protection by the countries from where the personal information is sent. DelAm will take appropriate technical and organizational measures to protect this personal information. If applicable, I understand I may access, rectify, delete or object to the processing of my personal information by sending a written communication to admin.metlifeexpat@alico.com (please identify employer and group policy number in written request).This authorization shall remain valid and effective from the date of signing until revoked by sending a written email communication to admin.metlifeexpat@alico.com or until the policy identified above expires, provided such information shall be retained if required by law.

To the best of my knowledge and belief, the information I provided in this claim form is true, complete, and correct.
I have read the applicable **Fraud Warning(s)** provided in this claim form.

Date (Authorized representative if Minor Child) Patient's Signature (If not patient) Employee Signature

**SUBMITTING A CLAIM**

**Please mail, fax, or email a signed, completed claim form with itemized bills and receipts to CoreSource at the address or fax number on page one of this form.**

**Medical, dental, and vision coverages are subject to exclusions and limitations. Please refer to your Schedule of Benefits for description of covered services, limitations, and exclusions.**

# ATTENDING PHYSICIAN'S STATEMENTS

## (Medical and Dental)

Your claim form contains a physician's statement for your convenience in filing your claim. Your doctor does not have to complete this statement if you have itemized bills or receipts of payment from the doctor. To be considered valid, your receipts must contain the following:

1. Name of the patient
2. Date of each service
3. Service performed
4. Amount charged for each service
5. The signature of the Provider or the Provider's representative
6. The Provider's name and address
7. The diagnosis (if confidentiality laws does not allow the provider to enter the diagnosis, enter the chief compliant on Part C of the claim form)
8. Drug bills must include the name of the medicine

## PART A

| Patient's Name: | Date of Birth: |
|---|---|
| Employee's name if patient is a dependent: | |

## PART B

| Diagnosis and Concurrent Conditions: | Accident Case? ☐ Yes ☐ No |
|---|---|
| (If accident case, please provide description) | |
| Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No | |
| Is condition due to pregnancy? ☐ Yes ☐ No If "Yes", what was the approximate date of LMP | |

**REPORT OF SERVICES** (Or attach itemized bill. If previous form submitted to this admission, you need only show dates and services since last report).

| Date of Service | Place of Service** | Description of Surgical or Medical Services Rendered (if hospital confinement, name hospital) | Procedure Code - if used (if Code other that CPT-4 is used, give name) | Charges |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total Charges: | |
| | | | Amount Paid: | |
| | | | Balance Due: | |

** ICD-10-CM - Int'l Classification of Diseases, 10th Rev. Clinical Modification

Place of Services (Use number Code)

1. Doctor Office
2. Patient's Home
3. Inpatient Hospital
4. Outpatient Hospital
5. Nursing Home
6. Home Health Care
7. Surgical Center
8. Alcohol-Chemical Rehabilitation Center
9. Other Briefly Described

I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN PERFORMED AND THAT THE FEES CHARGED DO NOT EXCEED THE FEES CHARGED TO PRIVATE AND NON-INSURED PATIENTS.

| | | | | |
|---|---|---|---|---|
| | | | | |
| Physician's Name (Print) | Physician's Signature | Degree | Telephone No. | Date |

| | | | |
|---|---|---|---|
| | | | |
| Street Address | City or Town | State or Province | Zip/Postal Code |

**FOR PHYSICIANS ONLY**

| | |
|---|---|
| Physician's Taxpayer ID Number: | Do you Accept Assignment?<br>☐ Yes ☐ No |

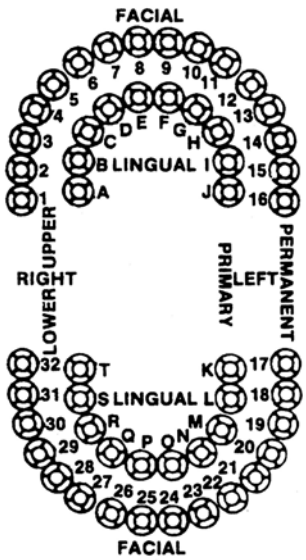
## PART C - COMPLETED BY DENTIST

| | | | | | | |
|---|---|---|---|---|---|---|
| Dentist Name: | | | Is Treatment Result of Occupational Illness or Injury? | No ☐ | Yes ☐ | If YES, Enter Brief Description and Dates |
| Mailing Address: | | | Is Treatment Result of Auto Accident? Other Accident? | No ☐ | Yes ☐ | |
| City, State, Zip: | | | Are any Services covered by another Plan? | No ☐ | Yes ☐ | |
| Dentist Soc. Sec. ORT. I.N. | Dentist License No | | If Prosthesis, is this Initial Placement? | No ☐ | Yes ☐ | If No, Reason for Replacement<br>Date of Prior Replacement |
| Dentist Phone No. | | | | | | |
| First Visit Date Current Series | Radiographs or Models Enclosed?<br>☐ Yes ☐ No | If Yes, how many? | Is the treatment for Orthodontics? | No ☐ | Yes ☐ | If Services already Commenced, enter Date Appliances Placed |
| Place of Treatment<br>☐ Office ☐ Hospital<br>☐ Home ☐ Other | | | | | | Mos. Treatment Remaining |

DENTISTS
Pre-Treatment Estimate
Statement of Actual Services

Examination and Treatment Plan - List in Order Tooth No. 1 through Tooth No. 32
Use Charting System Shown

*Indicate Missing Teeth With an "X"




Remarks for Unusual Services

| Tooth # or Letter | Surfaces | Description of Services (Including X-Rays, Prophylaxis, Materials used , etc. | Date Services Performed Mo. | Da. | Yr. | ADA Procedure Number | Fee | For Carrier Use Only |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |
| | | | | | | | | |

I Hereby Certify that the Procedures as indicated by Date Have Been Completed

SIGNED DENTIST DATE

**Total Fee Actually Charged**

CLAIM NO.

# DIRECT DEPOSIT INTO U.S. BANKS

**Are you interested in Direct Deposit?**

I am already set up for Direct Deposit (do not complete the information below).

Yes, (please read and complete the information below).

No, please mail a check to my address (do not complete the information below).

## Authorization Agreement for USD Direct Deposit into U.S. Banks

### Authorization

The member authorizes CoreSource, Inc. (through ECHO Health Inc.), as administrator for Delaware American Life Insurance Company, to directly deposit benefits payable to the member into the U.S. bank account specified below for Medical, Dental, and/or Vision. **Please be aware that direct deposit setup will result in all payments to the member to directly deposit into their account**, including payments where CoreSource is not authorized to pay the servicing provider. If the member then owes that amount to the provider, the member will be responsible for forwarding payment to the provider.

### Activation

Setup requires five (5) business days from the date of receipt to activate.

### Documentation Requirements

The account specified below must be held by the member. **A voided check must be provided with this form. Deposit slips cannot be accepted.**

### Termination of Authorization

This authorization remains in effect until such time as the member notifies CoreSource **in writing** to terminate direct deposit procedures or ceases to be eligible for benefits under their plan.

### Changes to Account Information

It is the member's responsibility to notify CoreSource of any changes/updates to the banking information given on this form, or changes of e-mail address. All changes/updates must be in writing and dated, and require up to seven (7) business days from receipt to activate.

### Notification of Deposit

By providing an e-mail address the member authorizes all notifications of deposit to be delivered to this e-mail address instead of postal mail.

**I hereby authorize direct deposit to my U.S. bank account pursuant to the above stipulations:**

Member Name | Signature | Date

Account Holder Name | E-Mail Address

Bank Name | Checking or Savings

Bank Routing Number | Account Number

I have attached a voided check for my account (not a deposit slip).