IMPORTANT

HOW TO FILE A HOSPITAL CLAIM WITH S .USA

Filing a claim is simple with our *"Simple Claims"* system!
Here is what we need from you in order to process your claim in a timely and accurate manner:

- ✓ **Completed Claim Form (PSGHI 0823)**
- ✓ **Physician's Statement**
- ✓ **Explanation of Benefits**
- ✓ **Itemized Hospital Bill or HCFA 1500 or UB-04 form**

Please note: Itemized Hospital bills can be obtained directly from your provider. These bills must include dates of service, diagnostic/procedure codes and the amount you were charged for each service. The Company reserves the right to require additional medical records to document that there is proof of loss and that you are eligible for benefit payment.

It is important that you include your Certificate Number on your claim form. If you need assistance locating your certificate number, please contact your Claims Success Center at: 866-725-0777.

The Claim Form can be obtained any one of the following ways:

- Member Portal: Click Here
- Claims Portal: Click Here
- Phone: 866.725.0777
- Email: HospitalShieldClaims@arkgroup.com

Please submit all claims documentation using one of the following options:

- Secure Upload: Click Here
- Mail: P.O. Box 540217 Omaha, NE 68154

For Claims related questions, please contact the Claims Success Center.

- 866.725.0777
- HospitalShieldClaims@arkgroup.com

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SECURE UPLOAD OR MAIL HOSPITAL CLAIM FORM TO:

PROSPERITY LIFE GROUP®

The Ark Group
P.O. Box 540217
Omaha, NE 68154
Attn: Claims Department
Or
Claims Portal: Click Here

CERTIFICATE HOLDER ***(complete for all claims)***

Name (First, Middle, Last)	Date of Birth	Address (Street, City, State & Zip Code)
Social Security Number	Certificate Number	

PATIENT INFORMATION ***(if other than certificate holder)***

Name (First, Middle, Last)	Date of Birth	Address (Street, City, State & Zip Code)
Social Security Number	Certificate Number	

CLAIM DETAILS ***(failure to complete all sections and provide sufficient details may result in a delay in claims processing.)***

Patient's Name	Date(s) of Service *(MM/DD/YYYY)*	Illness or Injury	Description of Illness or Injury *(Please describe in full detail)*

ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that the answers I have made to the foregoing questions and the supporting information that I am providing is complete and true to the best of my knowledge and belief. I have read the fraud notices included on this form.

Named Insured's Signature _____ Date _____

Parent's Signature (if different than the Named Insured) _____ Date _____
(Parent's signature acceptable if patient is a minor)

Authorization for Release and Disclosure of Health Related Information

If signed as Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority.

THIS AUTHORIZATION IS COMPLIANT WITH HIPAA PRIVACE RULES

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager (PBM), medical facility, or other health care provider ("Providers") that has provided payment, treatment or services on behalf of the Insured named below within the past ten (10) years to disclose the entire medical record and any other protected health information concerning the Insured named below to the Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature on this Hospital Claim Form, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may:

1) Determine or fulfill responsibility for coverage and provision of benefits;
2) Administer claims;
3) Administer coverage; and
4) Conduct other legally permissible activities that relate to any coverage the Insured named below has with the Company.

This Authorization shall remain in force for twenty four (24) months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that: (A) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in: Arizona, Georgia, Illinois, Minnesota, New Jersey, New Mexico, North Carolina, Ohio or Virginia. This Authorization shall not remain valid for longer than: (A) the term of coverage of the certificate, if the claim is for a health insurance benefit or the duration of the claim if the claim is not for a health insurance benefit; and, (B) as to HIV-related information only, if the Insured resides/resided in Arizona. This Authorization shall remain valid for one hundred and eighty (180) days; and if the Insured resides in, or in the case of a death claim, was a resident at the time of death in Wisconsin, this Authorization shall remain valid for the certificate term or the pendency of a claim for benefits under the certificate, whichever is longer.

I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to The Company at P.O. Box 540217, Omaha, NE 68154, Attention: Chief Privacy Officer. I understand that a revocation of this Authorization is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that The Company has a legal right to contest a claim under an insurance certificate or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record of the Insured named below, The Company may not be able to make any benefit payments. I understand that the Insured or Insured's authorized representative may request a copy of this Authorization.

STATE FRAUD WARNINGS NOTICES

For your protection, the laws of several states (including those listed below) require that we provide you with the following statements.

General Fraud Warning: 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 may be guilty of a criminal offense and subject to penalties under state law.

Alabama Fraud Warning:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska Fraud Warning:
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 Fraud Warning:
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, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Fraud Warning:
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.

California Fraud Warning:
For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

Florida Fraud Warning:
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 in the third degree.

Hawaii Fraud Warning:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana Fraud Warning:
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 Fraud Warning:
Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act under law.

STATE FRAUD WARNINGS NOTICES (CONTINUED)

Kentucky Fraud Warning:
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, Virginia and Washington Fraud Warning:
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.

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

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

Ohio Fraud Warning:
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 Fraud 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.

Oregon Fraud Warning:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania Fraud Warning:
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 containing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico Fraud Warning:
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 Fraud Warning:
For your protection Texas 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.

Vermont Fraud Warning:
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.