Verification of Insurance and Claim Inquiries
(202) 367-5097
(800) 282-4495 U.S. and Canada

the Gateway Plans
CLAIM FORM

Mail All Claims to:
Gateway Claims
P.O. Box 33729
Washington, DC 20033

The Gateway Claim form is attached for your use. Please complete this form in the event of an accident or illness. After the claim form has been completed, detach and mail to the address listed above. PLEASE FOLLOW THE INSTRUCTIONS SHOWN BELOW. Keep these instructions and helpful hints (on reverse side) for future reference.

FILING A CLAIM FOR BENEFITS—INSTRUCTIONS

Who Files:

1. You must submit itemized bills for reimbursement if the provider (hospital, physician, etc.) requires payment at time of service.
2. If provider does not require payment at the time of service, an itemized statement for hospital or medical services can be submitted directly on your behalf.
3. Whether you or the provider submits a claim, a completed **Gateway Claim Form** must be received in our office to initiate claim review and processing.

Completing The Claim Form:

Section A

1. Must always be completed. If a question does not apply to your situation, answer "N/A".
2. Sign the AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION; your claim cannot be processed without this authorization signature.
3. Check appropriate box under AUTHORIZATION TO PAY BENEFITS. If the box is not checked, payment will be made to the Insured Person. Your signature is required for benefits to be paid directly to the provider.

Section B

1. This section is completed by the attending physician.
2. This section does not need to be completed if provider is billing directly.
3. This section does not need to be completed if itemized bills are furnished and attached to the Gateway Claim Form.

How To File Claim:

1. If submitting itemized bills, attach to the completed **Gateway Claim Form.**
2. ONLY itemized bills can be accepted.
3. After submitting the initial claim, subsequent itemized bills for the **same condition** can be submitted for processing without another claim form as long as your name, policy number, and certificate number appear on **EACH** bill for proper identification.
4. If the provider is submitting bill for services directly on your behalf, it is your responsibility to submit a completed **Gateway Claim Form.**
5. Mail all documents for processing to the **Gateway Claims Administration** at the above address.

When Benefits Are Paid:

1. All claims are subject to medical review. Additional medical records or other medical information may be requested if deemed necessary.
2. Benefits are determined according to the policy provisions after all claim documentation is received and claim review is completed. If the information is incomplete, delays may be experienced before actual processing can take place.

See Reverse Side

HELPFUL HINTS

1. **Gateway Claim Form is always required.** This is your responsibility since most medical providers (in the U.S.) do not complete claim forms. If the medical provider bills or submits a claim form of another type directly to Gateway Claims, a Gateway Claim Form will still be required. A new and separate Gateway Claim Form is required for each insured person or insured dependent, and/or for each separate illness or accident.

2. **Claim documentation** cannot be returned. You may want to make a copy of all claim documents submitted for your records—for example: claim form, itemized bills, and correspondence.

3. **Itemized bill for hospital and medical services** includes: date of service, patient name, diagnosis, type of service, and amount charged.

4. **For prescription drugs,** an itemized receipt should include name of prescribing physician, prescription number, patient name, date, drug name, and cost. Cash register receipts or canceled checks are not acceptable.

5. **Bills can become separated.** Always write your name, certificate number, and Gateway plan name on each bill submitted, whether or not it is attached to a Gateway Claim Form.

6. **Do you have coverage under any other insurance or national health plan?** Gateway is secondary (excess) coverage when benefits from another plan are also payable. To expedite processing time, submit your itemized bill to Gateway after other benefits have been considered (paid or denied), along with the Explanation of Benefits statements. Once Gateway Claims receives this documentation, the remaining benefits allowable under the Gateway plan can be processed.

7. **Outside the U.S.,** if you have trouble obtaining physician bills or bills are not available, the medical provider should complete and sign Section B of the Gateway Claim Form.

8. **Medical Records** from physicians are sometimes requested. If medical records are requested this will be noted on the copy of the EOB (Explanation of Benefits) sent to you and the provider from the Gateway Claims Administration office. Sometimes you can help speed this process by calling the provider's office to ask that the request be expedited as quickly as possible.

9. **Are you returning to your home country—has your mailing address for claim correspondence changed?** Be sure Gateway Administration always has your correct, complete address. Make sure providers submitting bills directly to Gateway Claims include your complete address. Apartment numbers, suite numbers, and correct zip or postal codes must appear on any claim documentation submitted. Incomplete addresses cause delay in processing and distribution of benefit payments.

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Check Plan Type: ❑ Gateway Visit America Policy #9027471 ❑ Gateway USA Policy #9017374 ❑ Gateway Premier Policy #9017675 ❑ Gateway International Policy #9017674 ❑ Gateway Global Policy #9023037

Underwritten by The Insurance Company of the State of Pennsylvania

SECTION A (Please type or print) To be completed by the Insured Person or Proxy

Name of Insured Person *(first name, middle initial, last name)* | Date of Birth *(month/day/year)* | ❑ Male ❑ Female | Certificate Number

Patient's name *(first name, middle initial, last name)* ❑ Male ❑ Female | Patient's relationship to Insured Person: ❑ Self ❑ Spouse ❑ Child | Patient's date of birth *(month/day/year)*

Permanent Home Address of Insured Person:

Number and street | Apartment number | Daytime telephone number

City | State | Country | Postal/Zip Code

Mailing Address for Claim Correspondence:

Mailing Address is valid until (month/day/year) | Is this mailing address new? ❑ Yes ❑ No

Number and street | Apartment number | Daytime telephone number

City | State | Country | Postal/Zip Code

Insured Person's Email Address:

Are you covered by any other medical insurance? ❑ Yes ❑ No

If you are covered by medical and/or travel insurance, give Insurance Company Name and Policy Number ____________________

If you are covered by national/government health plan, please describe ____________________

Is Claim due to an accident? If "YES" describe accident (how and where, attach a separate sheet if necessary) ❑ Yes ❑ No | Date of Accident Mo. _______ Day _______ Year _______ | Time of Day ❑ AM ❑ PM

Describe illness, condition or diagnosis | For this condition, is this: ❑ Initial Claim ❑ Subsequent Claim | Is this claim the result of a work-related illness or injury? ❑ Yes ❑ No

Date of first medical treatment for this or similar condition | Name of Physician

Have you ever been treated for this condition prior to starting the Gateway Plan? ❑ Yes ❑ No If "yes" give date

List the physicians that have treated the patient for any condition during the past 12 months (36 months if insured under Gateway Visit America). Attach a separate sheet if necessary.

Name of Physician	Address	Date of Treatment

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment of any benefits, directly to:

❑ Myself ❑ Doctor/Hospital ❑ Other Eligible Third Party (Employer/Sponsoring Organization) ____________________

Address (if not the same as Insured Person) ____________________

Signed (Insured Person): ____________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Must be signed before claim can be processed)

I hereby authorize any hospital, physician or other person who has attended me or examined me, to disclose when requested to do so by The Insurance Company of the State of Pennsylvania, Marsh Affinity Group Services or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. This authorization is valid for 180 days.

Insured Patient | Date | Adult Signature if patient is a minor | Date

PLEASE READ IMPORTANT INFORMATION ON REVERSE SIDE

Important Notice

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

In these states, the following notices apply:

CALIFORNIA - 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.

FLORIDA - Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim, containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 YORK - Any person who knowingly and with the 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA - 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 and subjects such person to criminal and civil penalties.

Section B - ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE DOCTOR IF ITEMIZED BILLS ARE NOT AVAILABLE

Date of illness (first symptom) or injury (accident) or pregnancy	Date first consulted you for this condition	Has patient ever had same or similar illness or injury?	If an emergency check here
Mo. ______ Day _______ Year________	Mo. _______ Day _________ Year _________	❑ Yes ❑ No	❑

Name of referring physician or other source	For services related to hospitalization give hosp. dates Admitted Discharged

Name and address of facility where services rendered (if other than home or office)

ICDA* Code:

1.

2.

Date of services	Place of services	Description of surgical or medical services rendered, used, (give name)	Procedure Code, if used (if code other than CPT** used, give name)	Charges
___________	________________	____	_______________________________	_______________
___________	________________	____	_______________________________	_______________
___________	________________	____	_______________________________	_______________

O	Doctor's Office	NH	Nursing Home	**Total Charges** $ __________________
H	Patient's Home	IH	Inpatient Hospital	
OH	Outpatient Hospital	OL	Other Location	**Amount Paid** $ __________________
*ICDA	International Classification of Diseases			
**CPT	Current Procedural Terminology (current edition)			**Balance Due** $ __________________

Signature of Physician or Supplier: ____________________________	Your Social Security Number	Total Charge	Amount Paid	Balance Due
Date: ____________________________	Your Tax I.D. Number	Physician's or supplier's name, address, zip and telephone no. (area code)		
Patient Account Number: ____________________________ ____________________________	Accept Assignment ❑ Yes ❑ No			