



Lasso Plus HIP Claim Form

Lasso Healthcare will pay the benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Limitations and Exclusions and all other policy provisions. Please refer to the Hospital Indemnity Policy for more benefit information.

Please complete all sections thoroughly. Failure to complete all sections may result in a delay in processing this claim. Please provide the invoice from the hospital to support this claim. Please review your policy for specific benefits covered under your plan

Section 1: Policyholder Information and Attestation

POLICYHOLDER'S FIRST NAME		POLICYHOLDER'S MIDDLE INITIAL		POLICYHOLDER'S LAST NAME	
POLICY NUMBER	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH		SOCIAL SECURITY NUMBER	
ADDRESS		CITY	STATE	ZIP CODE	PHONE #
E-MAIL ADDRESS					

Member Authorization: I authorize Lasso Healthcare Insurance Company (herein referred to as “Lasso Healthcare”), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed, including but not limited to prescription drug records, for claim servicing purposes. Upon presentation of this Authorization, or a photocopy of it, Lasso Healthcare may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for claim servicing purposes. Lasso Healthcare and its reinsurers may also obtain such information from the Medical Information Bureau (MIB).

Acknowledgement: I hereby certify that information provided on this claim form are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included with this claim form.

Policyholder's Signature: _____

Date: ____/____/____



Section 2: Medical Professional's Statement and Attestation

Patient Information:					
PATIENT'S FIRST NAME		PATIENT'S MIDDLE INITIAL		PATIENT'S LAST NAME	
POLICY NUMBER	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH		SOCIAL SECURITY NUMBER	
ADDRESS		CITY		STATE	ZIP CODE
Medical Condition and Treatment:					
ADMISSION DATE		DISCHARGE DATE		INPATIENT CONFINEMENT OR OBSERVATION	
REASON FOR HOSPITALIZATION		DATE OF INJURY (if applicable)		INITIAL DIAGNOSIS DATE/DATE SYMPTOMS FIRST APPEARED	
DIAGNOSIS DESCRIPTION/ ICD-10		PROCEDURE CODE (CPT/HCPCS)		PROCEDURE DESCRIPTION	
EXPECTED DELIVERY DATE (PREGNANCY)		DATE THE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS Yes <input type="checkbox"/> No <input type="checkbox"/>	
				IF YES, PLEASE GIVE DATE	
NAME OF HOSPITAL FOR INPATIENT CONFINEMENT OR OBSERVATION					
ADDRESS		CITY		STATE	ZIP CODE
					PHONE NUMBER



Medical Professional Information and Attestation:			
MEDICAL PROFESSIONAL'S NAME	NPI	SPECIALTY	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	

Provider Acknowledgement: I hereby certify that information provided on this claim form are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included with this claim form.

Medical Professional's Signature: _____ Date: ____/____/____

Please send the completed claim form and invoice from the hospital to:

Mail:

Lasso Healthcare Insurance Company
P.O. Box 60690
Harrisburg, PA 17106

Fax:

833-438-0474

Email:

hip@lassohealthcare.com

If you have any questions, please call Lasso Healthcare at 800-918-3743 (TTY: 711).

APPLICATION FRAUD NOTICES

ARKANSAS: 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.

KANSAS: 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 insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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.

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.

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.

UTAH: Please note that the state of domicile for Lasso Healthcare Insurance Company is Texas. 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.

ALL OTHER STATES NOT LISTED SEPARATELY: 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.