Bywater Manual Member Claim Form

MAIL COMPLETED FORM TO:	INSTRUCTIONS FOR FILING:	FOR BYWATER USE ONLY
Bywater, Ltd. 15422 Detroit Avenue Lakewood, Ohio 44107 ***For questions, call 800.337.0792***	1. Complete sections 1, 2 and 4 below. 2. Complete section 3 if accident or injury. 3. Attach hardcopy claim, fully itemized bill and/or primary Explanation of Benefits 4. Submit the completed form to Bywater. 5. Be sure to sign in appropriate locations. 6. Use a separate form for each patient.	

1. EMPLOYEE'S STATEMENT

Employee's Employer			( ) Active ( ) Retired ( ) COBRA
Employee's Name (Please Print Full Name)	ID Number	( ) Male ( ) Female	Date of Birth (mm/dd/yy)
Street Address	City, State, Zip		Telephone Number

Patient's Name	Patient's Birth Date
Relationship to Employee	Patient's Employer
Full Time Student ( ) Yes ( ) No	Patient's School

2. COMPLETE IF COVERED BY OTHER INSURANCE

Name of Person Covered	Name of Company	Policy #	Covered Person's Employer

3. COMPLETE IF ACCIDENT OR INJURY

Date Accident Occurred	Describe Injury Details (Where did it occur? How did it occur?)	
Was injury due to Patient's occupation? If yes, please explain. ( ) Yes ( ) No		Were any other family members involved? ( ) Yes ( ) No
		Was this an automobile accident? ( ) Yes ( ) No

4. AUTHORIZATION FOR RELEASE OF INFORMATION

To: All hospitals and other medical care institutions, physicians and other medical professionals, insurance institutions, employers, group policyholders, benefit plan administrators, independent claim administrators, and support organizations.
I authorize you to furnish Bywater, its agents, affiliates and subsidiaries with copies of records you may have concerning examinations, treatments including drug, alcohol or psychiatric treatments, if any, history, diagnosis, prescriptions, other medical information, information relating to medical expenses and any personal or employment related information which may relate to this plan. I understand that such will be used by Bywater for the purpose of evaluating and administering claims. This authorization shall be valid for the duration of this claim. I certify that the information I furnish in support of this claim is true and correct. I know it is a crime to fill out this form with information I know is false or to leave out facts I know are important.

Employee Sign Here: _____Date: _____ / _____ / _____

5. ASSIGNMENT OF BENEFITS

Sign below only if you want payment sent directly to provider (Doctor, Dentist, Hospital, Etc.).
I authorize payment of attached bill to Provider.

Employee Sign Here: _____Date: _____ / _____ / _____

Fraud Warnings

Any person who knowingly presents a false or fraudulent claim for payment of 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:

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

Florida:

WARNING: Any person who knowingly and with intent in 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.

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.

New York:

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 concerning any material 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:

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

Oregon

WARNING: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud

Rhode Island:

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.

Virginia:

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 include imprisonment, fines and denial of insurance benefits.