Important Notice Regarding Fraud

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, 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.
- ***For Residents of Alabama:*** 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 restitution fines and confinement in prison, or any combination thereof.
- ***For residents of California***: 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.
- ***For residents of 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.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** 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 of the third degree.
- ***For residents of 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.
- ***For residents of 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 include imprisonment, fines and denial of insurance benefits.
- ***For residents of 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.
- ***For residents of 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.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** 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 CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Important Notice Regarding Fraud

- ***For residents of 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.
- ***For residents of 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.
- ***For residents of Oregon:*** Any person who knowingly and 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 may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of 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.
- ***For residents of 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.
- ***For resident of 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 false or deceptive statement may have violated state law.

PROVIDENT®

FIRST NOTICE OF CLAIM

Provident - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800.447.0360
Fax: 412.963.0148
claims@providentins.com
www.providentins.com
Business Hours: 8:30 a.m. to 5 p.m.

THIS FORM IS ONLY ACCEPTABLE FOR USE WHEN APPLYING FOR MENTAL STRESS MANAGEMENT BENEFITS

BOTH SECTIONS MUST BE COMPLETED

Name		Date of Birth / /	Social Security Number
Address	City State Zip Code		Home Phone Number ( )
Email Address			Cell Phone Number ( )
What is your regular, full time occupation?		Employed By (Name of Company)	
Employer's Address	City State Zip Code		Employer's Phone Number ( )
Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed).		Wages/Earnings Hourly: Weekly:	Date of Hire (Full Time Occupation) / /
Time of Accident ☐ AM ☐ PM	Date of Accident / /	Place of Accident	Date Last Worked / /
What is your injury or illness?		How did it happen?	
Name and Address of Treating Physician		Name and Address of Hospital	
Did you lose any Time from Work? ☐ Yes ☐ No ☐ Unknown at this time		Did you file with Workers' Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /		Has Workers' Compensation approved your claim? ☐ Yes ☐ No	
I was partially disabled from / / to / /			
Date you have or are expected to return to work / / ☐ Expected ☐ Returned			

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON PAGES 3 AND 4 OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

☐ Yes ☐ No – Is the need for care due to a single emergency incident?

☐ Yes ☐ No – Is the care needed due to the accumulation of multiple emergency incidents?

☐ Yes ☐ No – Is the care unrelated to an emergency incident?

Is the claimant a ☐ Volunteer ☐ Career ☐ PT employee ☐ Auxiliary ☐ Other

See Fraud Warning Important Notice sheet attached.
Failure to complete this form in its entirety may result in a delay of processing your claim.

Policyholder _____ Policy Number _____

Provident - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800.447.0360
Fax: 412.963.0148
claims@providentins.com
www.providentins.com

Please sign and return this authorization to Provident Agency, Inc. (Provident) at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule.

Authorization to Disclose Psychotherapy Notes

I authorize _____ (print name of health care provider) ("Provider");
To disclose Psychotherapy Notes;
To the following persons: Provident for the purpose of evaluating and administering claims, including assistance with return to work.
This authorization applies to medical records created by Provider and to any records that Provider received from any other source as long as the other source has not prohibited disclosure of those records.
"Psychotherapy Notes" means notes about me, recorded in any form, by a health care provider who is a mental health professional; that document or analyze the contents of conversation during a private, group, joint or family counseling session; and, that are separate from the rest of my medical record. "Psychotherapy Notes" does not mean: medication prescription and monitoring; counseling session start and stop times; the modes and frequencies of treatment furnished; results of clinical tests; and, any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Provident may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Provident receiving notice of revocation.

The privacy protections established by HIPPA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws.

This authorization is valid for one (1) year from the date below, or the duration of my claim(s), whichever period is shorter. A copy of this authorization is as valid as the original.

_____ _____
(Claimant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

PROVIDENT®

DISABILITY CLAIM
(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
Provident; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Toll Free: 800.447.0360 Fax: 412.963.0148
claims@providentins.com

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident noted above.

I authorize _____ to release infromation from the record of:
Name of Facility/Person

_____ / / _____ _____ to
Patient Name Birth Date SS # / MR #

_____ _____ _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION):_____

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):
☐ Inpatient ☐ Emergency Department Dates:_____ to _____
☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☑ Mental Health Information ☑ Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

☑ Consults	☑ Medical History & Physical Exam	☐ Physican Orders
☑ Discharge Summary/Admissions History	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☑ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Reports Emergency	☐ Pathology Report	☑ Radiology Report
☑ Dept. Reports	☑ EKG Report (s)	
☐ Other:_____		

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature

Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Date of Signature

Signature of Authorized Representative ○ N/A

○ Parent or Legal Guardian ○ Power of Attorney
○ Next of Kin of Deceased ○ Executor of Estate

Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date Witness # 1 Date Witness # 2