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.

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
Provident Claims Services, Inc. - PO Box 38295
Pittsburgh, PA 15238-8295
Toll Free: 800.478.1752 Fax: 412.963.0148
claims@providentclaims.com

Please mail or fax this form to:

Provident Claims Services, Inc.
P.O. Box 38295
Pittsburgh, PA 15238
Phone: 800.478.1752 Fax: 412.963.0148

Email: claims@providentclaims.com

Business Hours: 8:30 AM to 5 PM

This form must be completed by the Claimant and be returned promptly for consideration of benefits. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please return this form as soon as possible after the first day you are unable to work. Please be sure to keep a copy of this form and any attachments for your records.

INSTRUCTIONS:

Authorization for Release of Protected Health Information: Sign, date, and return this form to Provident Claims Services, Inc.

Please enclose any additional information that you feel will assist us in evaluating this claim.

PROVIDENT | CLAIMS SERVICES

DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
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Pittsburgh, PA 15238-8295
Toll Free: 800.478.1752 Fax: 412.963.0148
claims@providentclaims.com

Authorization for Release of Protected Health Information

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **Provident Claims Services, Inc., on behalf of AXIS Insurance Company** or its designated administrator. This authorization shall remain valid for a period of two years from the date signed. A photo static copy of this authorization shall be considered as effective and valid as the original. A copy of the authorization is available upon request of the company.

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

_____ _____ and send to
Patient Name | Patient Address | City | State | Zip Code

_____ _____ _____
Patient Phone | Birth Date | SS # / MR #

Provident Claims Services, Inc. (412) 909-4991 (412) 963-0148
Name of Facility/Person | Phone | Fax

PO Box 38295, Pittsburgh, PA 15238
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): Insurance Benefits

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/Instructions	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☉ Operative Report	☐ Psychiatric/Psychological Eval
☐ Mammography Reports	☐ Pathology Report	☉ Radiology Report
☉ Emergency Dept. Reports	☉ EKG Report (s)	

☉ Other: Any and all psycholological treatment notes/progress reports

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