



S.USA LIFE INSURANCE COMPANY, INC.

A Prosperity Life Group® Company

Administrative Office: P.O. Box 161690, Austin, TX 78716 Toll Free Phone: 877.909.6269

LIMITED BENEFIT SUPPLEMENTAL OUTPATIENT PRESCRIPTION DRUG MEMBER CLAIM FORM

Please include your certificate number on your claim. If you need assistance locating your certificate number, please contact our Customer Care Center at 877-909-6269.

To avoid delays in processing, please fill out the sections and pages which apply to your claim. You may fax your completed claim form to 512-275-9350 or mail your form to:

Bay Bridge Administrators, LLC.
P.O. Box 161690
Austin, TX 78716

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

A prescription receipt or pharmacy printout from the dispensing pharmacy is required for each prescription for which a claim is being submitted.

The drugs for which you are requesting payment must be clearly identified on the receipt or history and include the following information: Dispense Date, Eleven-Digit National Drug Code (NDC), Medication Name, Strength, Dose, Quantity, Day's Supply, Amount Paid, Prescriber's Name, the Prescriber's National Provider Information (NPI) Number, as well as the Total Cost of the prescription.

- **Please submit your receipts TAPED to a separate piece of paper with this form.**
- **Step 1: Member Information**
- **Step 2: Authorization for Release of Health-Related Information.**
- **Step 3: Complete only if information is missing from your receipt OR Step 3 can be completed by your pharmacist or physician IF you do not have a receipt.**
- **Step 4: Member Signature.**
- **Step 5: Submit claim to address provided at the top of the form.**

STEP 1: MEMBER INFORMATION

(To be completed by member)

Cardholder ID #

Group Number

Cardholder's name *(Last)*

(First)

(MI)

Street address

City

State

Zip Code

**PART 2. AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION
TO BAY BRIDGE ADMINISTRATORS, LLC**

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager (PBM), medical facility, or other health care provider that has provided payment, treatment or services on behalf of the Insured named below within the past 10 years (“Providers”) to disclose the entire medical record and any other protected health information concerning the Insured named below to Bay Bridge Administrators. LLC and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Bay Bridge Administrators. LLC may:

1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the Insured named below has with Bay Bridge Administrators. LLC.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that: (A) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in, Arizona, Georgia, Illinois, Minnesota, New Jersey, New Mexico, North Carolina, Ohio or Virginia, this Authorization shall not remain valid for longer than: (1) the term of coverage of the policy if the claim is for a health insurance benefit; or (2) the duration of the claim if the claim is not for a health insurance benefit; and, (B) as to HIV-related information only, if the Insured resides/resided in Arizona, this Authorization shall remain valid for 180 days; and, (C) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in Wisconsin, this Authorization shall remain valid for the policy term or the pendency of a claim for benefits under the policy, whichever is longer. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Bay Bridge Administrators. LLC at P.O. Box 161690, Austin, TX 78716, Attention: Claims Department. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Bay Bridge Administrators. LLC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record of the Insured named below, Bay Bridge Administrators. LLC may not be able to make any benefit payments. I understand that the Insured or Insured’s authorized representative may request a copy of this Authorization.

Name of Insured or covered Dependent if over 18 (please print)

X _____

Signature of Insured or Dependent if over 18

Date

Description of Personal Representative’s Authority

STEP 3: ENTER INFORMATION FOR: PRESCRIPTION DRUGS
(Complete only if information is missing from the receipt or you do not have a receipt.)

Drug Name & Strength	NDC (National Drug Code)	Quantity Dispensed	Ingredient Cost	Days' Supply	Vaccine Administration Fee or Dispensing Fee	Total Cost

Pharmacy Name _____
 Pharmacy NPI Number _____
 Physician Name _____
 Physician NPI Number _____

If you do not have a receipt this section must be completed and signed by a pharmacist or physician.

Pharmacist or Physician Signature: _____

FRAUD WARNING

For your protection, the laws of several states (including those listed below) require that we provide you with the following statements.

GENERAL FRAUD NOTICE: 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 a criminal offense and subject to penalties under state law.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, 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.

California and Texas: For your protection California and Texas law require the following to appear on this form: 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.

Delaware and Idaho: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing false, incomplete or misleading information is guilty of a felony.

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 in the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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 purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia 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 may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or any 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 claim for each such violation.

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.

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.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 containing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claims to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

STEP 4: MEMBER SIGNATURE

Claim payments are subject to satisfaction of any applicable Outpatient Prescription Drug Deductible and Policy Deductible. Total benefits payable during a Plan Year may not exceed the Outpatient Prescription Drug Maximum Benefit per Plan Year per Covered Person or per Family, as applicable.

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.

By signing you acknowledge that the above information is true to the best of your knowledge and belief.

Signature _____ Date: _____