iCHIP
Assurance Everywhere

Claim Form

Helpful Tips

- Please submit this completed Claim Form with the itemized bills and receipts.
- A separate Claim Form is needed for each member.
- Please tape small receipts on a full size sheet of paper.
- Failure to provide acceptable proof of loss or to complete all sections of this form will result in claim processing delays.
- Seven Corners processes claims for iCHIP.
- Send this signed form and any accompanying documents to Seven Corners within 180 days from the date of service using any of the methods listed to the right.

Call for help: 1-800-335-0477 (toll free)
or 317-575-2656 (worldwide)
or 317-818-2809 (collect)

Upload
Login to **My Account** and upload your documents
www.sevencorners.com/myaccount

Fax
(+1) 317-575-2256

Email
ichip.claims@sevencorners.com
(email attachments can not be larger than 10 MB.)

Mail
(Allow mail 7-10 days for delivery of a check.)

Seven Corners, Inc.
Attn: iCHIP Claims
PO Box 211379
Eagan, MN 55121 USA

The furnishing of this form, or its receipt by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract. Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Reason for Claim

You may check more than one. ☐ Medical ☐ Dental ☐ Maternity ☐ Vision ☐ Wellness

Principal Member Information (Must be completed)

1 Group name		2 ICHIP Certificate number	
3 Principal Member's full legal name			
4 Street address			
5 City	6 State/Province/Region	7 Postal Code	8 Country
9 Member's telephone number		10 Mobile Number	
11 Communications should be sent via e-mail to			

Patient/Member Information (Must be completed)

12 Patient's full name	
13 Patient's date of birth MM/DD/YYYY	14 Member/Cert ID
15 Gender ☐ Male ☐ Female	16 Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other

Other Insurance Coverage (Must be completed)

17 Do you hold any other insurance related to the loss?	**18** Other insurance carrier name
19 Other insurance policy number	**20** Policyholder name
21 Have you filed these claims with the other insurance? ☐ Yes ☐ No	

Medical Information (Please include diagnosis or reason for visit)

- For charges related to an accident, details of the accident along with a police report, death certificate, autopsy, coroner, and/or toxicology reports, etc. must be provided.
- For conditions that have required long term treatments, please provide details of when the symptoms and/or treatment began.
- Claims for prescribed drugs or medications should include a prescription from your GP or medical specialist.
- When other insurance is used include detailed invoice listing amount under that policy

Date of Services (MM/DD/YYYY)	Name and address of provider's physician (or clinic, hospital, pharmacy, dentist)	Description of service; name of medication; device (if hospital, state inpatient, day case or outpatient)	Diagnosis (reason for visit)	Country of claim	Currency of claim	Total charge

22 If the claim is for maternity benefits, please indicate the expected due date of the pregnancy (MM/DD/YYYY)	**23** Please advise if your pregnancy is a result of assisted conception / infertility treatment
24 For dental claims, please indicate the location of the tooth and ensure itemized breakdown of service is included	**25** Were your injuries caused by an accident? ☐ Yes ☐ No
26 If **Yes**, is it motor vehicle related? ☐ Yes ☐ No Accident Date: ____________ Time:____________ ☐ a.m. ☐ p.m.	**27** Work related? ☐ Yes ☐ No Accident Date: ____________ Time:____________ ☐ a.m. ☐ p.m.
28 Attach details of accident (if applicable)	

Prescriptions

- Include prescription details. Must include name of drug, dosage, and frequency.

29a List prescription medications you are taking or took during the past 6 months not related to your injury or illness.	**29b** List prescription medications prescribed for your injury or illness.

Summary of Payment Details (must be completed)

To prevent any delays in claims handling, please be sure to sign this form.
The ***Name*** in box 1 must match exactly the name on the ACH, checking, or wire transfer account. Joint accounts require all names.

Reimbursement Election – Please check one of the following options if you want to:

☐ Receive future payments using the method provided below

☐ Use the payment method provided below for this claim only

☐ Use the payment method that we already have on file for you

1 Contact Information

Name of Account Holder(s)			
Email Address	Telephone number		
Mailing Address			
City	Country	State	Zip/Postal code
(P.O. boxes are not accepted; **Note:** If receiving reimbursement by check, this is the address that it will be sent to.)	I authorize Seven Corners, Inc. to contact me using this email address to discuss and/or inform me of payment confirmation. ☐ **Yes** ☐ **No**		

2 Payment Type (Must be completed)

Method of payment:

☐ International Wire Transfer / ACH – complete section 3 ☐ Check – complete section 1, check will ship to address in section 1

3 Banking Information (Complete where applicable)

Account Type: ☐ Checking ☐ Savings	Beneficiary Bank Name:		
Beneficiary Bank Address			
City	Country	State	Zip/Postal Code
Account Number	Routing Number		
IBAN	SWIFT Code	Preferred Reimbursement Currency	
Intermediary Bank Name (Complete for bank transfer outside the U.S.A.)			
Intermediary Bank Address			
City	Country	State	Zip/Postal Code

Authorization

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer, relative or benefit plan administrator to furnish to Seven Corners, Inc. any and all information with respect to any injury or illness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, illness or loss is the basis of the claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the policy identified above. I authorize the group policyholder, employer or benefit plan administrators to provide Seven Corners, Inc. with financial and employment related information and documents. I agree that I will provide Seven Corners, Inc. with any medical records, or other records, requested by Seven Corners, Inc. to process the claim. I understand that my failure to provide requested documents to Seven Corners, Inc. may result in denial of the claim. I understand that failure by any of the above referenced entities or individuals to provide information or documents to Seven Corners, Inc. may result in denial of the claim. In addition, I hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that any false statements made on this form or omissions of information requested by this form may result in denial of the claim. I acknowledge and understand the Fraud Notices on Page 5 of this document.

I hereby authorize Seven Corners, Inc. (Hereinafter COMPANY) to mail any payments to the above listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize COMPANY to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree COMPANY is not responsible for any transaction fees charged and will release Seven Corners of any liability in the event of lost or stolen payments.

Member Signature (Required)	Date

Fraud Warnings & Disclosures

- General: 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.
- 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, Louisiana, Maryland, 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: 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.
- Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
- Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
- 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.
- 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.
- 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.
- Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.
- Maine: 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.
- Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files 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 the person to criminal and civil penalties.
- Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.
- 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 section 638:20.
- New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- 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.
- 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.
- 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 concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- 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.

YOU DO NOT NEED TO RETURN THIS PAGE TO US