

# **ManhattanLife Limited Benefit Group Supplemental Insurance Member Claim Form**

Underwritten by: ManhattanLife Insurance Company  
Administered by: Bay Bridge Administrators, LLC

Please include your certificate number on your claim. If you need assistance locating your certificate number, please contact our Claims Department at 800-845-7519.

To avoid delays in processing, please fill out the sections and pages which apply to your claim. You may mail, email, submit via online portal, or fax your completed claim form to:

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

**Email:** [claims@bbadmin.com](mailto:claims@bbadmin.com)  
**Portal:** [portal.bbadmin.com](http://portal.bbadmin.com)  
**Fax:** 512-275-9350

**Please read the following instructions and complete this form carefully:**

1. Completely fill out Parts 1 and 2 (Part 3 is optional).
2. Sign and date Part 4.
3. Remember to provide your Social Security Number and a copy of the Explanation of Benefits (EOB) from your major medical plan.
4. Attach a copy of your Explanation of Benefits (EOB) from your provider or hospital. The EOB will contain the amount your primary medical plan applied to your deductible, co-insurance, and/or co-pay.

Please note that if the EOB does not contain a description of the services provided, we will also need the UB-04 Form from your hospital or CMS-1500 Form from your provider. These forms are the standard billing forms utilized by healthcare facilities and providers. Your documentation should provide complete information on:

- a) Provider's Name and Address
- b) Provider's Tax Identification and NPI Number
- c) Diagnosis Code (ICD-10)
- d) Charges/Cost of each treatment
- e) Procedure Code (CPT)
- f) Place of Service Code

5. Please submit your claim via mail, email, online portal, or fax provided on this form.

## **FRAUD WARNING**

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, 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.

**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:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

**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.

**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 may include imprisonment, fines or a denial of insurance benefits.

**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.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**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.

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

**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 claim containing a false or deceptive statement may have violated the state law.

**Pennsylvania and all other states:** 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.

## PART 1. CERTIFICATE HOLDER INFORMATION (REQUIRED FOR ALL CLAIMS)

Full Name (As it appears on your Social Security card):

Date of Birth:

Social Security Number:

Mailing Address:

Apt. #:

City:

State:

Zip Code:

Phone #:

E-mail Address:

Employer/Group Name:

Employer/Group Phone #:

Policy Certificate Number:

This claim is for:

☐ Self

☐ Spouse

☐ Dependent

## PART 2. PATIENT INFORMATION (IF CLAIM IS FOR SPOUSE OR DEPENDENT CHILD)

Full Name (As it appears on Social Security card):

Date of Birth:

Social Security Number:

Relationship:

Phone #:

## PART 3. PROVIDER INFORMATION (ALL FIELDS REQUIRED FOR PAYMENT TO PROVIDER)

Would you like this claim to be paid out to your Provider?

☐ Yes

☐ No

*If yes, please provide:*

Provider's Name:

Provider's Phone #:

Provider's Address:

Provider's NPI #:

Provider's Tax-ID #:

## PART 4. MEMBER SIGNATURE

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.

**The above Statements are true to the best of my knowledge and belief.**

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

**STEP 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



## BAY BRIDGE ADMINISTRATORS

We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- ☐ Better cash management forecasting - accelerated funds availability – certainty of delivery
- ☐ Establishment of excellent payment and credit records
- ☐ Being part of "Going Green" by reducing paper

Enrolling means payment will deposit into your bank account, eliminating use of paper checks and mail delays. We will continue to send you the corresponding Explanation of Benefits via regular mail.

### Frequently Asked Questions

**How do I get started?** Complete and sign the Direct Deposit Authorization Agreement Form. Below reflects where you find the bank routing/bank account numbers that need to be included.

The diagram shows a check with various fields. A bracket on the left side of the check, labeled "Bank Name and Address", points to the fields: "My Name", "My Address", and "My City, State, & Zip". Another bracket at the bottom of the check, labeled "9 Digit Bank Routing Number", points to the number "123456789". A third bracket at the bottom, labeled "Your Account Number", points to the number "12 34567890". The check also shows a "Pay to the order of" field, a "\$" field, and a "Dollars" field. The number "101" is visible in the top right corner and at the bottom right of the check.

**What is the process of enrolling in ACH?** Once we receive your completed form, the form is sent to the team that builds the ACH set up.

**How long does the ACH enrollment process take?** It could take up to 3 business days for the ACH to become effective.

**What needs to happen if we change account numbers or financial institutions?** If you want to change your ACH electronic authorization, please complete another Direct Deposit Authorization Agreement Form and submit it. Include a note on the form indicating this is for a change in information.

**How long does the ACH authorization remain in effect?** Your authorization will remain in effect until we receive notification from you that you prefer receiving a check in the mail.

# ***Indemnity Policy Benefit Payment Direct Deposit Authorization Agreement***

\_\_\_\_\_  
First Name MI Last Name SSN

\_\_\_\_\_  
Street Address City State ZIP Code

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Bank Name Account No. Routing/Transit No. Account type: ☐ Checking ☐ Savings

\_\_\_\_\_  
Bank Address: Street, City, State, Zip Name(s) on Bank Account

Please Attach Voided Check Here

I (we) hereby authorize Bay Bridge Administrators, LLC hereinafter call "Company" to initiate credit entries to my (our) account indicated above at the depository financial institution named above, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

\_\_\_\_\_  
Authorized Signature Date  
(Signature must match signature card on account)

Bay Bridge Administrators, LLC.  
P.O. Box 161690, Austin, TX 78716  
Phone: (800) 845-7519 Fax: (512) 275-9350  
Email: [underwriting@bbadmin.com](mailto:underwriting@bbadmin.com)  
Website: [www.bbadmin.com](http://www.bbadmin.com)

