

**The Prudential Insurance Company of America
as administered by illumifin Corporation (DBA in California: illumifin Administration)**

Claim Transmittal Form

This form is required when submitting claims without an industry standard form (i.e., CMS/HCF-1500 - Professional; UB-04 - Hospitals). If you do not have one of the standardized forms, please complete the information below. Use 1 (one) Claim Transmittal Form for each provider of service. Type or print information clearly.

Claim Transmittal Forms (P-Form) must be signed and dated within one year of the date of service listed on the claim being submitted for processing.

Section A: Insured Information

1. Name (Last Name, First Name, Middle Initial)		2. Policy Number		3. Phone Number ()	
4a. Street Address		4b. City		4c. State	4d. Zip Code
5. Date-of-Birth (mm/dd/yyyy)				6. Gender <input type="checkbox"/> M <input type="checkbox"/> F	

Section B: Patient Information

1. Name (Last Name, First Name, Middle Initial)		2. Relationship to Insured		3. Phone Number ()	
4a. Street Address		4b. City		4c. State	4d. Zip Code
5. Date-of-Birth (mm/dd/yyyy)				6. Gender Assigned at Birth <input type="checkbox"/> M <input type="checkbox"/> F	
7. Patient Status (check each one that applies)		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		<input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student	
8. Employment Status (check each one that applies)		<input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled		<input type="checkbox"/> Receiving/entitled to receive Govt Benefits or Pd Leave. If so please provide _____ <input type="checkbox"/> Other, please explain _____	

Section C: Claim Information

9. Is Patient's condition related to

a. Employment? No Yes if yes, date of accident (mm/dd/yyyy) / /

b. Auto accident? No Yes if yes, date of accident (mm/dd/yyyy) / /

c. Other accident? No Yes if yes, date of accident (mm/dd/yyyy) / /

10. Is the Patient covered by any other health insurance? If Yes, complete item 11. <input type="checkbox"/> No <input type="checkbox"/> Yes		11. Other insurance company name, policy number and effective date. a. Name b. Policy Number c. Effective Date *Please note: If your Prudential Individual Health policy coordinates benefits with Medicare, please provide the Medicare Explanation of Benefits with your claim submission.	
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Section D: Authorization for Release of Information to Prudential Insurance Company

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives for the purpose of processing this claim. 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. I understand this authorization will expire 24 months from the date the authorization is signed. I also understand that I may revoke this authorization at any time by providing Prudential with written notice of revocation.

Print Name of Patient: _____	
_____ Patient's Signature (if minor, guardian's signature)	_____ Date

Section E: Authorization of Payment

If you want payment sent to the provider of service, authorize that request by signing below. If you want payment directed to you, please do not sign this authorization and be sure the attached bills clearly do not assign payments.	
I authorize payment of medical benefits to the provider of service.	
_____ Patient's Signature (if minor, guardian's signature)	_____ Date

Section F: Instructions for Submitting Claims

Attach original bills and receipts to this form. All documents must be legible (typed or neatly printed). Bills and receipts must be submitted within 12 months of the date of service and must display the policy number, patient name, date(s) of service, billed amount, and contain the following items:

Procedure Codes: Standard codes used to explain what services were rendered.

Diagnosis Codes: Standard codes used to explain what illness/body part is being investigated/treated.

Revenue Codes: Only for hospital charges. Defines the area of the hospital or type of charges being billed.

Provider Tax ID: Either a Federal Tax Identification Number or the provider's Social Security Number.

All forms must be mailed to: The Prudential Insurance Company of America
As administered by illumifin Corporation
ATTN: Health Services Division
PO Box 64372
St. Paul, MN 55164-0372

Section G: Certification of Statement

Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by a person, or if a person conceals, for the purpose of misleading, information concerning any fact material thereto.

Alabama Residents: 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 Residents: 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 Residents: 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, Massachusetts and Rhode Island, West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California and Texas Residents: For your protection, California and Texas 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.

Colorado Residents: 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 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 with the Department of Regulatory Agencies.

Delaware Residents: 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 Residents: 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 Residents: 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.

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

Indiana Residents: 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 Residents: 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, Tennessee, Virginia and Washington Residents: 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.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: 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 Residents: 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. The Prudential Insurance Company of America as Administered by illumifin Corporation Toll Free Customer Service Number: (800) 828-0153.

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

NEW MEXICO RESIDENTS: 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 Residents: 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.

North Carolina Residents: Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a Class H felony.

Ohio Residents: 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 Residents: 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 Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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

Puerto Rico Residents: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

Vermont Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

I have read the fraud notice above and hereby certify that all statements provided by me on this form are correct and that all supporting documents submitted by me with this form are correct and represent actual services, dates and fees charged to me or my eligible dependents for which no reimbursement has been previously received for any of these services.

Insured's Signature _____

Date _____