RCM&D

A UNISON RISK ADVISORS Company

IMPORTANT INFORMATION ABOUT YOUR INSURANCE PLAN AND HOW TO FILE A CLAIM

FOR INFORMATION ABOUT YOUR ELIGIBIITY, BENEFITS or CLAIM STATUS:

» **Contact ACI** at Toll free # 888-293-9229 within the US or Canada or
610-293-9229 if you are Outside the US or Canda

Email: aciclaims@acitpa.com
Hours of Operation: 8 am – 8 pm EST, Monday through Friday

HOW TO FILE A CLAIM

» **File your claim electronically via the RCM&D Claim Intake site** https://portal.acitpa.com/rcmd by creating an account and selecting the Accident & Sickness medical Claim Form RCM&D

or

Submit a manually completed claim form via email, Fax or postal mail to ACI

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Email: aciclaims@acitpa.com
Fax: 610-293-9299
EDI: 22384

» **Fill out** the claim form completely including the group policy # and your assigned member id # (listed on your insurance id card)

» **Be descriptive** in regards to the service the doctor performed. Past medical history, dates of the condition and/or symptoms were first experienced and addresses of prior physicians.

» **Attach any accompanying documentation** (i.e, itemized bills, payment receipts and if applicable medical records, injury report or primary insurance evidence of Benefit Statement)

» Remember, if a question applies to your situation, please answer it!

CLAIM REIMBURSEMENT REQUEST (only available for claims that have already been paid to the medical provider). For Claims that have not already been paid, ACI will issue payment directly to the medical facility or provider.

- **Attach** your paid receipt, itemized bills, statements and invoices for services and supplies.
  - Please make sure that all documents indicate claimants name, date of service, diagnosis and the itemized charges.
  - If you are requesting the payment on behalf of someone else such as for your parents or a minor child, please write that the payment should be made out to you. Add payment information to the claim form itself, or attached a separate cover letter with explanation.

RX

When submitting prescription drug charges for reimbursement, you are required to send more than a cash register receipt. Please submit the Pharmacy receipt listing the Pharmacy name, your name, date, drug, and amount dispensed.

TIPS

- Keep copies of all the documents submitted. There is no guarantee that your submission will always make it to our office via postal service.
- You need to submit a new claim for each family member and for each new medical condition being treated.
- You need to file the claim within 90 days. However, you are recommended to file as soon as you avail the medical service.
- After you submit the claim, you should follow up with ACI periodically to make sure the process is going smoothly.
- It is the Insured Person's responsibility to make sure that the claim form, original bills, supporting claim documentation, etc. are submitted timely and completely.
- If you want someone to speak with ACI on your behalf by calling (888)293-9229, please complete and send an "**Authorization to Disclose Personal Health Information"** to ACI. This form is also attached for your convenience.

Claim Processing Timing and Procedure

The insurance company will process complete claims within 2 to 4 weeks after receiving the claim information. If additional information is required, you will be informed by a formal letter. You should follow the instructions carefully and arrange for the documents to be submitted back to the requestor. Many claims are pending for a long time solely because the insurance company is waiting for the provider to send medical documentation. Please follow up with your provider to make sure that they have provided the required information. Once the claim is processed, for all

eligible claims, ACI will make the payment. If you paid at the time of service, reimbursement will be made to you.

In either case, you will receive and EOB that will describe the services rendered and filed for the claim, what charges were covered, what charges were not covered and why. The EOB may also list your due amount that you should pay to the provider if you have not already paid.

ADMINISTRATIVE CONCEPTS, INC.

PO Box 4000 • Collegeville PA 19426 • Telephone: (888) 293-9229 • Fax: (610) 293-9299 • www.acitpa.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDEDTO ASSIST IN THE PROCESSING OF A CLAIM FILED UNDER THE INSURANCE POLICY

I hereby authorize Administrative Concepts, Inc. to obtain **Protected Health Information** and to disclose such PHI tothe individual(s) or entity(ies) indicated below, for the *express* and *limited* purpose of assisting in the processing of myclaim.

Information to be Used or Disclosed May Include:

[ ] Provider name, address & specialty (required)
[ ] Dates of service (required)
[ ] Cost of services (required)
[ ] Medical diagnosis (optional)
[ ] Services rendered (optional)
[ ] Medications (optional)

Persons or Class of Persons to Whom the Disclosure May be Made:

[ ] Student Health Service Staff
[ ] Student Affairs Staff
[ ] Employer
[ ] Association Representative
[ ] A Specific Individual, as follows: _____

I understand that individually identifiable health information relating to me, which is called *Protected Health Information* as defined by the *Privacy Rule* of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA);* and,
that if the person or entity that receives this information is not a business associate, health plan, health care clearinghouse, or health care provider as defined in the *HIPAA Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,
that I may revoke the authorization at any time by notifying Administrative Concepts, Inc. *in writing*. However, if I choose to do so, my revocation will not affect any actions taken by Administrative Concepts, Inc. *prior* to my revocation; and,
that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
This authorization expires 365 days after signing or upon my request to Administrative Concepts, Inc. to terminate the authorization, whichever is earlier.

Insured Member's Name: (print)

Member ID Number _____ Date of Birth: ____/____/____

Claimant is: [ ] Self [ ] Dependent (print full name and indicate relationship to insured)

_____

Patient's or Authorized Representative's Signature:

Date: ____/____/____ If Authorized Representative, Relationship to Patient:_____

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy and the applicable law. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein. Neither this communication nor any further communications that we may have regarding this claim should be construed to waive any of these rights and defenses. We are willing to review any additional information that you may provide. We further reserve all of our rights to assert defenses based upon other policy provisions and applicable law, whether or not specifically mentioned herein.