ITALIAN CATHOLIC FEDERATION

# HOSPITALIZATION PLAN CLAIM FORM

**IMPORTANT** CHECK HERE IF KAISER ☐

Name:_____ Member #_____ Branch:_____

Address:_____ City:_____ State:_____ Zip:_____

I was hospitalized for_____ day (s) from_____ to_____. Surgery **WAS** performed ( ) Surgery **WAS NOT** performed ( )

AUTHORIZATION TO RELEASE INFORMATION: I authorize the attending physician or authorized representative to report below the reason for my hospitalization/surgery. Patient's signature:_____ Date:_____

**PRIMARY PATIENT DIAGNOSIS (CIRCLE ONLY ONE)**

Doctor's or Doctor's Representative's signature_____

A02 ABSCESS
A03 ADVERSE DRUG AFFECT (skin rash, allergy)
H09 ANAL DISEASE, OTHER
A07 ANEMIA
A08 ANGINA
A08 ARTERIES, DISEASES OF
R04 ARTHRITIS, RHEUMATOID
A14 ASTHMA
B01 BRONCHITIS
B03 BURSITIS
B04 BIOPSY
C01 CARDIAC ARREST
C02 CATARACT
C03 CEPHALALGIA (tension headache)
C04 CEREBRAL ISCHEMIA
C04 CEREBRAL THROMBOSIS
C04 CEREBROVASCULAR DISEASE ACUTE (cerebral vascular accident)
C09 CHOLECYSTITIS
C10 CIRRHOSIS, ALCOHOLIC (laennec's)
C10 CIRRHOSIS, OTHER (portal)
C12 COLITIS, ULCERATIVE
C13 COLON DIVERTICULA (itis)
C14 COLON IRRITABLE (spastic)
C15 COMMON COLD, ACUTE (coryza, rhinitis)
C16 CONGESTIVE HEART FAILURE
C17 CONJUNCTIVITIS
L07 CONNECTIVE TISSUE DISEASE (collagen disease nonvascular)
C19 CONVULSION (seizure)
C20 CYSTIC DISEASE OF BREAST
D01 DIABETES MELLITUS
E01 ECZEMA, DERMATITIS
E03 EMPHYSEMA
E05 ENDOCARDIUM, CHRONIC
E05 ENDOCARDITIS (other)
E08 ESOPHAGUS, DISEASE OF (esophagitis)
E09 EYE, OTHER
F01 FRACTURE
H07 FIBRILLATION, AURICULAR
H07 FIBRILLATION, VENTRICULAR
G01 GASTRIC DISORDER (other)
G01 GASTROENTERITIS
G04 GLAUCOMA
G06 GOITER
G08 GONOCOCCAL INFECTION
G09 GOUT (hyperuricemia)
H01 HAYFEVER
C03 HEADACHE (vascular)
H03 HEART DISEASE, CHRONIC (arteriosclerotic heart disease)
H04 HEART DISEASE, OTHER (rheumatic heart disease)
H05 HEART DISEASE, HYPER-TENSIVE
H07 HEART RHYTHM DISORDER
H08 HEART VALVE ANOMALIES
H09 HEMMORHOIDS
H10 HEPATITIS
H12 HERNIA
H05 HYPERTENSION, BENIGN
H06 HYPERTENSION, MALIGNANT
H17 HYPOTHYROIDISM
H18 HIP REPLACEMENT
I01 INFLUENZA
I02 INVERTEBRAL DISC DISEASE
K01 KIDNEY DISORDER
K19 KNEE REPLACEMENT
L01 LABYRINTHITIS (otitis interna)
L02 LEUKEMIA, ACUTE
L03 LEUKEMIA, CHRONIC
L04 LUMBAGLIA (lower back pain)
L05 LUNG, DISEASES OF (pneumonia, other)
N01 LUNG, MALIGNANT NEOPLASM
L07 LUPUS ERYTHEMATOSUS
M01 MENOPAUSAL SYNDROME
M03 MENTAL DISORDER (chronic brain disorder)
M04 METABOLIC DISEASE, OTHER (hyperlipemia)
M09 MASTECTOMY/LUMPECTOMY
C04 MIGRAINE (headache)
H04 MITRAL VALVE DISEASE
M07 MONONUCLEOSIS, INFEC-TIOUS
M08 MYOCARDIAL INFARCTION, ACUTE
N01 NEOPLASM, MALIGNANT UNSPECIFIED (cancer)
N02 NERVE DISEASE, PERIPH-ERAL (carpal tunnel syndrome)
N03 NERVE DISEASE, PERIPH-ERAL (peripheral neuorpathy)
N04 NEUROSIS
N07 NEOPLASM, BENIGN
O01 OBESITY, EXOGENOUS
O02 OSTEOARTHRITIS (degenerative)
O03 OTITIS EXTERNA
O03 OTITIS MEDIA
P01 PANCREATIC DISORDERS (hypoglycemia)
P02 PANCREATITIS
P04 PARALYSIS, SPASTIC
P05 PARASITIC DISEASE, OTHER
G08 PELVIC INFLAMMATORY DISEASE
T04 PHARYNGITIS, ACUTE
P08 PHLEBITIS (thrombo lower extremity)
L05 PLEURISY
L05 PNEUMONIA (unspecified)
P11 MATERNITY
N07 PROSTATE HYPERPLASIA
P13 PROSTATITIS
S06 PSORIASIS, OTHER
R01 RENAL DISEASE
R02 RETARDATION SEVERE
R03 RETINA, LESIONS (vascular)
R04 RHEUMATISM
S06 SEBORRHEA
S04 SINUSITIS
S06 SKIN DISEASE
S07 SPRAIN, NECK
S08 SPRAIN, BACK
S09 SPERMATOCELE
T01 THROMSOCYTOPENIA
T02 THYROIDITIS, ACUTE
T03 TONSILITIS
T04 T & A HYPERTROPHY
T05 TOXIC EFFECT (bee sting effect)
U01 ULCER, PEPTIC
U02 ULCER, SKIN, CHRONIC
U03 URETHRITIS
U04 U R I ACUTE
U05 URINARY TRACT INFECTION
N07 UTERINE FIBROMA
V01 VAGINITIS & VULVITIS (atropic vaginitis)
P08 VARICOSE VEINS
P08 VASCULAR DISEASE
100 ACCIDENT RELATED (trauma)
200 ANATOMIC REPAIR
300 CONGENITAL ANOMALY
400 INFLAMMATION OR INFECTION
500 OTHER (not listed)

**RATE OF REIMBURSEMENT: Effective 6/21/14**
**SURGERY = $100**
**1ST DAY = $75**
**2ND DAY = $50**
**3RD + DAY(S) @ $25 x ____ = $_____**

*****Remember, claims must be filed within one year of the date of service.*****
*****You must submit a copy of the hospital bill or a print-out from Kaiser showing the dates of your hospital stay, etc. as verification of the information filled out on the claim form.*****
*****For hospital stays prior to 6/21/14 the previous benefits apply: 1st day = $50.00, 2nd day = $25.00, 3rd day = $10.00 and surgery = $75.00.*****

**GRAY AREA FOR REFERENCE ONLY** **MEMBER'S DUES**

**DIAGNOSIS CODE** ☐ **PAID TO** ☐ **TOTAL CLAIM:** $ ☐

Italian Catholic Federation

# Hospital Claim Procedure

To file a claim, you must have stayed a **minimum of one night** in an ***acute care*** facility approved by the State Board of Health, *or*, had **surgery** in a State licensed surgical center. ***Stays in convalescent or rehabilitation facilities are not covered by this plan***.

**Claims must be made within <u>one year</u> of the surgery or hospital stay**. When submitting a claim, please complete the following three steps. ***Paperwork lacking the dates and signatures requested will be returned for resubmission***.

**(1)** Complete all information in the upper, boxed section of the Claim Form. ***Be sure to sign the Authorization to Release Information***.

**(2)** KAISER PATIENTS ONLY- Check the "Kaiser" box at the top right of the form. When submitting your claim, you do *not* need to include a copy of your bill. However, we would appreciate a print-out from Kaiser showing the dates of your hospital stay, etc. as verification of the information filled out on the claim form.

**(3)** Be sure that the doctor, nurse, or facility representative has...

- **CIRCLED** the Diagnosis Code.
- **SIGNED** on the line below "Patient Diagnosis."

**(4)** Mail the Claim Form ***with a copy of the hospital bill*** to:

**Italian Catholic Federation**
8393 Capwell Drive, Suite 110
Oakland, CA 94621
Phone: (510) 633-9058
Fax: (510) 633-9758
Toll Free: 1-888-423-1924

*The Italian Catholic Federation is a duly incorporated religious and fraternal organization. Hospital/Surgery benefits are available to members of the I.C.F. who are enrolled in the Plan and who are current in their membership dues. The cost of the Plan is $25 a year. Benefits are available to members in whose name the Plan is taken out and may not be assigned to another. To obtain enrollment information, contact the Financial Secretary of your I.CF. Branch or the I.C.F. main office at the address and phone number listed above.*

Rev. 6/21/14