AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

to an Authorized Individual/Personal Representative

I, _____, policy number _____, hereby authorize the use and disclosure of my protected health information, as it relates to coverage, billing, and claims administration, or as defined, or as limited to the following:

_____

_____

Continental Casualty Company may release my protected health information as described above to the following person(s):

Financial Health Services, LLC, by its Pre-Certification Specialists: Kris Jones, Jeannette Kudach, Kelly Kieserman Kelly Fleckenstein, Janyne Wieder, Belle Swartz, Chelsea Brown, Jalil Vazquez, Jackie Givnish 484-674-3760

Printed Name of Authorized Individual — Phone Number

325 Sentry Parkway, Building 5 East, Suite 160

Street Address

Blue Bell — PA — 19422

City — State — Zip Code

This form is for use and disclosures only. It does not authorize anyone other than me or my legal representative to make any changes to my coverage, billing, or demographic information. I understand that if the person or entity that receives my information is not covered by the federal privacy regulations, my information may be re-disclosed by such person or entity and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge by my signature below that I have read and understand this Authorization, that it accurately reflects my wishes, and that a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

Signature of Insured or *Legal Representative — Date

*If you are signing as a legal representative, describe the scope of your authority to act on the insured's behalf and include a copy of the documentation of your legal authority.

Long Term Care Claims Department
PO Box 64912, St. Paul, MN 55164
Phone Number 1-800-262-1037
Facsimile 952-983-5194

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to FINANCIAL HEALTH SERVICES, LLC for any insurance benefits otherwise payable to me by CNA / CONTINENTAL CASUALTY COMPANY for services rendered by the referenced provider. I understand that I am financially responsible for charges not covered and/or any coinsurance amounts due in accordance with my policy.

Claimant's Name _____ Policy Number _____

Signature of Claimant or Authorized Representative _____ Date _____

Provider Tax I.D. Number: _____

Provider's Address: (Name) Financial Health Services, LLC

(Address) 325 Sentry Parkway, Building 5 East, Suite 160

(City/State/Zip) Blue Bell, PA 19422

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Notice

In an effort to ensure payments are disbursed to the correct provider, the attached W-9 Form must accompany this request. Please have your Provider complete the W-9 Form in its entirety and return to the address referenced above. If the Assignment of Benefits form is received without the W-9 form your request will be delayed. Any benefits that are payable will be issued directly to the insured until all requirements are received.