Brella

Greenhouse Life Insurance Company
Administered by Brella Services Inc.
Attn: CLAIMS
2093 Philadelphia Pike #2496
Claymont, DE 19703

With Brella, it's easy to file a claim.

It just takes a few minutes to submit a claim online at joinbrella.com or through the Brella app. You'll enjoy faster processing time and we'll send you updates on your claim electronically.

If you'd rather not file a claim online, you can use this paper form to submit your claim to us by mail or fax.

If you have questions, call your Brella Concierge at 1 (888) 300-5382.

Before you submit your claim

Double check that you are submitting a claim for a covered condition. You can look up your condition by logging in to your Brella account or call your Brella Concierge at the number above.

Also, be sure to gather any documentation that proves that you were diagnosed with this condition by a licensed medical provider. Taking these steps before you submit your claim can help you avoid a delayed or denied claim.

How to use this form

Please read all instructions and be sure to completely fill out the form. If you provide an incomplete claims submission, this could delay the processing of your claim.

- Do not write on the form except as instructed.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Sign, date, and fax or mail your completed claim submission, along with your supporting documentation, to the Brella fax number/address shown below.

In addition to the claim form, please submit four supporting documents that confirm your claim, including the condition(s) you had and the date you were diagnosed. If you don't have four documents, send us at least two documents. A Brella Concierge will be in touch with you if we need more information. Here are examples of the types of supporting documentation you can submit:

- Hospital discharge paperwork
- Summary of care
- Statement of benefits
- Ambulance call report
- Image of hospital wristband
- Image of a prescription for medication
- Image of a prescription medication bottle
- A doctor's bill
- A medical facility bill
- A lab bill
- Lab reports
- Test results
- Imaging results

If you'd like us to work directly with your providers to request additional documentation, please complete the **HIPAA Authorization Form** attached and submit it with your claim and supporting documentation.

Mail your complete claim submission form and supporting documentation to us at:

Greenhouse Life Insurance Company
Administered by Brella Services Inc.
Attn: CLAIMS
2093 Philadelphia Pike #2496
Claymont, DE 19703

You can also fax your documents to the Brella Claims Department at 1 (856) 315-6567.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member. You can find an electronic version of this form at https://joinbrella.com or you can request additional forms by calling your Brella Concierge at 1 (888) 300-5382.

¿Necesitas ayuda en español? Llama al (888) 300-5382 para recibir ayudar, de lunes a viernes de 8 a.m. a 8 p.m. o los sábados de 9 a.m. a 3 p.m. en horario central.

Brella

Claim Submission Form

Please complete all the fields below and print clearly in blue or black ink.

Claimant information

The claimant is the Brella member for whom this claim is being submitted.

First name _____ **Middle name** _____

Last name _____ **Suffix** _____

Relationship to Primary Member (e.g. self, spouse, child) _____ **Date of birth** _____

Primary member's employer _____ **SSN** _____

Street address _____

City _____ **State** _____ **Zip code** _____

Phone number _____ **May we leave a message at this number?** **Yes** **No**

Primary Member Information

The primary Brella member is the person who enrolled in Brella at work. You may write 'same as above' if you are a primary member filing a claim for yourself.

First name _____ **Last name** _____

Date of birth _____ **SSN** _____

Employer Name _____

Tell us what happened

Answer each question below and be as specific as possible.

What symptoms did you experience?

What did your provider tell you was wrong?

What treatment did you receive?

Is there anything else we should know?

Tell us where you were treated

Name of treatment facility (you may list multiple): **Type(s) of facility:** (circle all that apply) Doctor's Office Urgent Care Hospital Inpatient Emergency Room Outpatient Surgery Other: _____
Date of Service:

By signing below you attest that you have provided truthful information on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

_____ _____ _____

Claimant Signature (or Authorized Representative) **Claimant Name** (please print) **Date**

_____

Representative Relationship to Claimant

Greenhouse Life Insurance Company

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF INSURANCE CLAIM DETERMINATION

Name of Insured: _____ Date of Birth: _____

Address: _____

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided treatment or services to me or on my behalf within the past 2 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Greenhouse Life Insurance Company and to their third-party administrator, Brella Services, Inc. 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 I have made to restrict my protected health information does 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 my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Greenhouse Life Insurance Company may administer claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: **Brella Services, Inc.** 2093 Philadelphia Pike #2496 Claymont, DE 19703 Attention: Claims Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that Greenhouse Life Insurance Company 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 re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Greenhouse Life Insurance Company may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

_____

Print Name of Individual or Authorized Representative Date Signed

COMPLETE AND RETAIN A COPY FOR YOUR RECORDS

Return form to: Brella Services Inc., Attn: Claims, 2093 Philadelphia Pike #2496 Claymont, DE 1970 or fax to 1 (856) 315-6567