



Allstate
You're in good hands.

Med Central Houston
PO BOX 440519
KENNESAW GA 30160



ROBERT PLOCK
6827 LATTA PKWY
DALLAS TX 752276043

July 05, 2013

INJURED PARTY: ROBERT PLOCK
DATE OF LOSS: January 25, 2013
CLAIM NUMBER: 0291823375 CMM

PHONE NUMBER: 877-224-2641
FAX NUMBER: 859-290-5555
OFFICE HOURS: Mon - Fri 8:00 am - 4:45 pm,
Sat 8:00 am - 2:30 pm

Your Personal Injury Protection Claim 0291823375

Dear ROBERT PLOCK,

I am sorry to hear of your recent injury, and I wish you a speedy recovery.

I want to make sure you know that you may be owed benefits under Your Personal Injury Protection coverage. Please rest assured that I will do my best to handle this for you as quickly as possible.

To assist you through this process, I have included some *Helpful Hints for Your Medical Claim*, which includes important information and commonly asked questions. In addition, we have provided helpful information you can share with any providers you seek treatment with related to this auto accident. This will help expedite any medical bill handling.

In case I need your medical records for any questions, I have included a "Medical Authorization" form. Please sign this form and return it to me in the envelope I have provided.

Simply complete and return the enclosed Application For Benefits. This form provides us with information that will help us properly evaluate your claim.

Allstate Insurance Company, an auto insurance carrier, makes available Voluntary Provider Networks including certain specialties and facilities. The use of a provider from these networks is strictly voluntary and is provided as a service to you.

You do not need to take any action. Should your medical provider participate within the network, your bills may be priced accordingly. A penalty will not be applied if you choose to select a provider outside the network. Voluntary Provider Networks maintain their lists of participating providers. Please let me know if you would like contact information for the Allstate participating networks utilized in your state.

0291823375 CMM



Please feel free to contact me for any questions or concerns you have about your claim.

On behalf of your agent, WICKMAN AGENCY, thank you for giving us the opportunity to serve you.

Sincerely,

MARK MCPHAIL

MARK MCPHAIL
877-224-2641 Ext. 2779457
Allstate Insurance Company

Enclosure(s)



Helpful hints for your medical claim

MEDICAL BILL QUESTIONS & ANSWERS



Where do I send documents related to my medical claim?

Please send copies of documents related to treatment as a result of the motor vehicle accident on January 25, 2013 to:

Med Central Houston
PO BOX 440519
Kennesaw, GA 30160

Please write your claim number 0291823375 on each document so we can quickly identify it as being part of your claim. Or, if it is more convenient, you can fax your medical correspondence to 859-290-5555.

If I have a prescription bill, what should I do?

Please send us prescription receipts that include fill date, quantity, prescribing doctor and prescription name.

Will the medical payments be mailed to me or my provider?

We usually send payment to your providers. We will gladly pay you directly as long as there are no liens or assignments of benefits from your provider.

How long will it take for my bills to be handled?

In general, we handle a bill within 30 days. If we need additional information, we will work with you and your provider.

How will I know when the handling of my medical bills is complete and what was paid?

With the handling of each bill, you and your provider will receive an Explanation of Benefits, which provides details regarding the handling of your particular bill.

What do I do if I receive a balance due bill from my provider?

Send us the bill or call us at 877-224-2641 Ext. 2779457

MEDICAL COVERAGE QUESTIONS & ANSWERS



What costs are included in my medical payments coverage?

In general, most policies cover the reasonable and necessary medical expenses, subject to policy limits, that you have incurred as a result of the accident. Please contact me if you would like specific details about your coverage.

What if I have medical bills and charges that exceed the coverage limit under my policy?

All policies contain a limit that represents the most that we can pay. If you have medical bills that exceed the policy limit, the handling of those bills will have to be coordinated with any other medical insurance you may have available to you, such as a personal health policy.

Why would my medical bills not be paid in full?

Sometimes we may not be able to pay a bill in full; for example, if the bill is a duplicate or if you have exhausted your policy limit. You and your provider will receive an Explanation of Benefits (EOB) with the specific reason. Please call us with any questions.

Will you reimburse me for my health insurance co-pay?

Yes. We will reimburse you for co-pays for reasonable medical expenses related to the accident within the policy limit. Just send us a copy of the bill.

GENERAL INFORMATION



What is a medical authorization and why do I have to sign it?

In order to expedite claim handling and properly evaluate your claim, we may need to obtain medical records and itemized billing. Due to HIPPA Privacy regulations, a signed release is required before your providers can release this information to us. This form will help ensure that we can obtain the bill(s) and medical records needed to process your claim as quickly as possible.

When will I hear from Allstate?

We will contact you periodically to discuss the status of your claim, or if we have any questions. Feel free to call us anytime regarding your medical claim.



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Helpful Information for Provider

FOR PROVIDERS ONLY

- If you would like to enroll in electronic billing, please contact 888-445-2510 between the hours of 8am and 5pm, Eastern Time. You can enroll online at <https://edidirect.acs-inc.com> and click on “Claims Payers List,” then “Allstate.”
- If you intend to file a lien or have the insured party execute an assignment of benefits, please mail a copy to the address indicated above and provide a copy to our insured as well.
- To insure quick response, please follow these guidelines:
 - Submit claims using standard HICFA forms
 - Include the (company) claim number
 - Specify diagnosis codes and CPT codes
 - Include a detailed description for any miscellaneous or unspecified procedure codes.
 - Please include any and all medical records related to treatment



Authorization to Release Medical Records This authorization contains the **core elements** outlined in the Health Insurance Portability Accountability Act (HIPAA). A property/casualty insurer is submitting this authorization.

Patient's Name: _____
Date of Birth: _____
Date of Loss: _____

Social Security Number: ***-**-_____
Address: _____

1. I authorize the use or disclosure of the above named individual's health information as described below for the purpose of handling their personal injury claim.

2. The following individuals or organization are authorized to make the disclosure: all persons with knowledge of my medical history

3. The following persons or class of persons may receive disclosure or protected health information about the above named person:

Allstate Insurance Company.

4. The type of information to be disclosed includes: (Please **initial** the items checked below authorizing the release of these medical records, if such records exist)

By **initialing** the items marked below, I specifically authorize the release of the following medical records, if such records exist: (Please **initial** all medical records you are authorizing)

- | | |
|--|--|
| --- <input type="checkbox"/> All hospital records (including nursing records and progress reports) | --- <input type="checkbox"/> Clinician office chart notes |
| --- <input type="checkbox"/> Medical records needed for continuity of care | --- <input type="checkbox"/> Dental records |
| --- <input type="checkbox"/> Transcribed medical records | --- <input type="checkbox"/> Physical Therapy records |
| --- <input type="checkbox"/> Most recent five year history | --- <input type="checkbox"/> Emergency and urgent care records |
| --- <input type="checkbox"/> Laboratory reports | --- <input type="checkbox"/> Billing statements |
| --- <input type="checkbox"/> Pathology reports | --- <input type="checkbox"/> Other: |
| --- <input type="checkbox"/> Diagnostic imaging reports | |
| --- <input type="checkbox"/> All medical records (all information). | |

5. _____ By **initialing** this area, I understand that the information in my health records may include information indicating the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) or Human Immune Deficiency Virus (HIV). It may also include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

6. Unless otherwise revoked, this authorization will expire on the following date, event or condition: for one year from the date of signature.

7. I also understand that I can revoke this authorization at any time by notifying company in writing. I understand that the revocation will not apply to information that has been released in response to this authorization.

8. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that THIS IS NOT A RELEASE OF MY CLAIM. I understand that the evaluation of my claim is based on the information available to Allstate Insurance Company. I understand that signing this form does not mean I have settled my claim.

CONDITION OF TREATMENT

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Use of Information

Allstate Insurance Company and its representatives will use this information to verify and evaluate my claim in order to determine an appropriate resolution. In some instances, Allstate Insurance Company may also furnish the information to professional organizations whose purpose is to detect and deter insurance fraud. We may furnish it to other insurance companies to whom a claim has or may be submitted. We may disclose copies of the bills and or medical records to third parties as needed to seek reimbursement or repayment of benefits paid under the policy.

A photocopy of this authorization is as valid as the original.

Signature of patient or authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative

Date

If signed by a Legal Representative, relationship to patient

Claim Number: 0291823375 CMM
Insured: ROBERT PLOCK



APPLICATION FOR BENEFITS – AUTOMOBILE PERSONAL INJURY PROTECTION

ALLSTATE INSURANCE COMPANY

DATE July 05, 2013	OUR POLICY HOLDER ROBERT PLOCK	POLICY NUMBER 000036207328	DATE OF ACCIDENT January 25, 2013	FILE NUMBER 0291823375
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: Med Central Houston
PO BOX 440519
KENNESAW, GA 30160

YOUR NAME ROBERT PLOCK		PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH		SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY.				
AT TIME OF ACCIDENT : WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR ? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR ? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE YOU A PEDESTRIAN ? <input type="checkbox"/> YES <input type="checkbox"/> NO				
OTHER AUTOMOBILES IN YOUR FAMILY:		INSURED BY 1. _____ (NAME OF 2. _____ COMPANY) 3. _____		
1. _____ 2. _____ 3. _____		1. _____ OWNER 2. _____ 3. _____		
ARE YOU A MEMBER OF OUR POLICY HOLDER'S HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO				
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.				
SIGNATURE		DATE		
DESCRIBE YOUR INJURY				
WERE YOU TREATED BY A DOCTOR <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF 1 ST TREATMENT DOCTORS'S NAME AND ADDRESS				
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU <input type="checkbox"/> AN IN-PATIENT <input type="checkbox"/> AN OUT-PATIENT		HOSPITAL'S NAME AND ADDRESS		
AMOUNT OF MEDICAL BILLS TO DATE: \$		WILL YOU HAVE MORE MED. EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		AT THE TIME OF THE ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, AMOUNT LOST TO DATE: \$		WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?
IF YOU LOST TIME : DATE DISABILITY FROM WORK BEGAN : DATE YOU RETURNED TO WORK :				
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER (1) ANY WORKMEN'S COMPENSATION LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, AMOUNT OF MEDICAL & WAGE (2) ANY OTHER SOURCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (NAME) _____ \$ _____ <input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH				
LIST NAME AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.				
EMPLOYER NAME AND ADDRESS		OCCUPATION	FROM	TO
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN ON REVERSE SIDE.				
SIGNATURE		DATE		

0291823375 CMM





ALLSTATE GROUP-CLAIMS
Med Central Houston
PO BOX 440519
Kennesaw GA 30160-9821
UNITED STATES

Fold here: address must appear in return envelope window



ALLSTATE GROUP-CLAIMS
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PO BOX 440519
Kennesaw GA 30160-9821
UNITED STATES

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The office identified above provides claims handling services for the Allstate Group of Insurance Companies, including the underwriting company referenced on the documents accompanying this insert.

