FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

CANCER AND ICU CLAIM FORM

Instructions: 1. Have the claimant answer all questions, sign and date SIDE 1.
2. Have the treating physician complete SIDE 2.

If filing a **cancer claim** submit one claim form for each hospital admission along with all itemized hospital bills, doctor bills, surgery bills from the surgeon with an attached pathology report, and chemotherapy/radiation bills.

If filing an **intensive care claim** submit one claim form for each hospital admission along with a copy of the itemized hospital bill listing the intensive care charges and an ambulance bill, if applicable.

1. Policyowner's Name: _____ 2. Policy #: _____

3. Claimant's Name: _____ 4. Social Security No.: _____

5. Address: _____ 6. Phone number: ( ) _____

_____ 7. Date of Birth: _____

8. Relationship to Policyowner: _____ 9. Describe illness/injury: _____

10. Date first consulted physician: _____ 11. Date diagnosed: _____

12. Have you ever had this condition before? ❑ YES ❑ NO If YES, when? _____

13. List all treating physicians. Include name and phone number:

_____

_____

14. Name and phone number of family physician:

_____

_____

15. Name and phone number of other physicians:

_____

_____

16. If hospitalized, when? From _____ to _____ Hospital phone: ( ) _____

17. Hospital name: _____
city state

18. Have you ever filed a claim for this condition with Family Heritage? ❑ YES ❑ NO

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy benefit manager or prescription data base, including prescription drug records, insurance company, or MIB, Inc. to furnish to Family Heritage Life Insurance Company of America or its representative or permit said insurance company or its representative to review for the purpose of evaluating claims for benefits any information with respect to any illness or accident, medical history or medical records. I understand that a photostatic copy of this authorization shall be considered as valid as the original and shall remain valid 30 months from the date signed. I further understand that I or my authorized representative may request a copy of this authorization.

Signed _____ Date _____
Claimant, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Patient's Name_____ Policy Number: _____

Cancer Claims:

1. When was **any** type of cancer first diagnosed? _____ Diagnosis code(s): _____

2. When did you first consult the most recent condition? _____

3. Is this a recurrence of a previous cancer? ❑ YES ❑ NO If YES, give date of recurrence: _____

List date of last known cancer treatment: _____ Type of treatment: _____

4. List name of referring physician: _____ Phone number: _____

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

6. If outpatient, list dates of service: _____

7. What services were rendered during the period listed above?

❑ biopsy ❑ surgery ❑ chemotherapy ❑ radiation ❑ hospice ❑ skilled nursing

8. Please provide any applicable surgery CPT procedure code(s): _____

_____

9. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Intensive Care Claims:

1. Has the patient **ever** been diagnosed with or treated for a heart attack, heart disease or stroke? ❑ YES ❑ NO

If YES, date of first diagnosis: _____ If YES, date of first treatment: _____

2. List reason for hospitalization: _____

3. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

If YES, when? _____

4. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

5. List specific dates of intensive care confinement: _____

6. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and phone number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____