# Critical Illness Claim Filing Instructions

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We or "Humana."

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by Kanawha Insurance Company, Humana Insurance Company, Humana Insurance Company of New York or Humana Insurance Company of Kentucky.

**Page One – Filing Instructions**

- Complete the appropriate sections of the claim form (page 2)
- Attach the documentation required for the condition(s) (page 6).
- Include the signed and dated Authorization Form (page 3)
- Submit to the address or fax to the number below.

**Page Two – Critical Illness Claim Form – Insured Statement**

- Complete all questions in both sections of the claim form
- Sign and date the claim form.

**Page Three – Authorization Form**

- The Authorization to allow physicians to release medical records to Kanawha Insurance Company, a Humana company.
- Please make certain the Claimant or Authorized Representative sign and date the form.

**Page Four - Physician Information**

- If the claim is being filed for services within the first two years following the policy effective date, the claimant must complete this form with all physicians seen and medications taken within the 5 years prior to the effective date of the plan.

**Page Five – Critical Illness Claim Form – Attending (Treating) Physician Statement**

- Ask your attending (treating) physician to complete this section.
- This form must indicate the details of the claimant's condition, dates of diagnosis and referring physician information.
- Page six provides the physician with the exact medical documentation to attach to the claim form in order to document the critical illness being claimed.

- Before mailing your claim form, please be sure you have included all items listed above to prevent delay in processing of your claim.
- The required medical documentation is submitted for the condition**.**
- Retain a copy of all information submitted for your records.

If you have any questions when completing this form, please call 1-877-378-1505.

**Mail to the following address:**

**Humana**
P.O. Box 13068
Green Bay, WI 54344

**Or Fax to:** 1-502-405-7107

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# Critical Illness Claim Form – Insured Statement

## Section I – General Information:

**Is the claim for the:** ☐ Policyholder ☐ Dependent

Policyholder's Name ____________________________________________ Policy No. ____________

Mailing Address ____________________________________________ Social Security No. __________

City ______________________ State ________ ZIP Code __________ Date of Birth ____ /____/______

Daytime Telephone No. (______)_______________

Email Address (optional): ____________________________________________

Please provide an email address to receive email notification of claim payment.

Do you have any other medical coverage? ☐ Yes (attach explanation of benefits) ☐ No If yes, Medical ID No. __________

Claimant Name ____________________________________________ Date of Birth ____ /____/

______ Type of critical illness/condition for which the claim is being made:

- ☐ Heart Attack
- ☐ Heart Transplant
- ☐ Stroke
- ☐ Coronary Artery Bypass
- ☐ Invasive Cancer
- ☐ Malignant Melanoma
- ☐ Cancer In Situ
- ☐ End Stage Renal Disease
- ☐ Severe Burns
- ☐ Coma
- ☐ Major Organ Transplant
- ☐ Permanent Paralysis
- ☐ Occupational HIV
- ☐ Loss of Vision, Hearing, or Speech

## Section II – Physician Information:

***Attending (Treating) physician:***

| Physician's Name | Address | Phone Number |
|---|---|---|
| | | |

Has the claimant ever been treated for the same or a similar condition in the past? ☐ Yes ☐ No

If yes, Please provider the prior physician information:

| Physician's Name | Address | Phone Number |
|---|---|---|
| | | |

Has the claimant ever been Hospitalized for this condition? ☐ Yes ☐ No

If yes, Please provider the prior physician information:

| Hospital Name | Address | Date of Admission |
|---|---|---|
| | | |

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 7 and 8)

***The above statements are true to the best of my knowledge and belief.***

____________________________________________ ____ /____/______

*Signature of Policyholder* *Date*



Mail to: Humana
PO Box 13068
Green Bay, WI 54344

Customer Service: 1-877-378-1505
Fax Number: 1-502-405-7107

**Authorization to release information -** For the Use and Disclosure of Protected Health Information

TO: Any physician, medical practitioner, hospital, pharmacy benefits manager, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.

2. I authorize all health care professionals to disclose my protected health information.

3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.

4. I authorization the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.

5. I authorize only designated staff of Kanawha Insurance Company, a Humana Company to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.

6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be redisclosed and would no longer be protected.

7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Kanawha Insurance Company P.O. Box 13068 Green Bay, WI 54344. This revocation shall become effective on the date it is received by Kanawha Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

**I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein.**

| ______________________________ | ______________________________ | _____ /_____/_____ |
|---|---|---|
| *Signature* | *Printed Name* | *Date* |

I have legal authority* under the laws of the State of ____________________________ to make health care decisions on behalf of __________________________________, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

| ______________________________ | ______________________________ | _____ /_____/_____ |
|---|---|---|
| *Name of Authorized Representative/Parent or Guardian* | *Relationship to Applicant* | *Date* |

* A copy of the legal authority document must be on file with Humana/Kanawha HealthCare Solutions, Inc.

***If the claim is being filed for services within the first 2 years following the policy effective date, complete the physician and medication information below:***

**Physician information:**

*List all physicians that treated the patient in the five years prior to the policy effective date:*

| Physician's Name | Address | Phone Number | Reason for Visit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Medication information:**

*List all medication being taken by the patient:*

| Medication | Prescribing Physician | Date Prescribed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Critical Illness Claim Form – Attending (Treating) Physician Statement

### Section I – Patient Information:

Patient ‘s Name ____________________ Policy No. ____________

Street Address ____________________ Date of Birth ____ /____/______

City ____________ State ________ ZIP Code __________

### Section II – Treatment Information:

Diagnosis or Condition for this patient ____________________ ICD’9/ICD’10 Code ____________

Date the symptoms first appeared: ____ /____/_______ Date of the first visit: ____ /____/_______

Date of the definitive diagnosis : ____ /____/_______ Date of surgery (CABG): ____ /____/_______

Has the patient been treated for this same or a similar condition prior to this occurrence? ☐ Yes ☐ No

If yes, list the date(s) of prior treatment: ____________________

Was this patient referred to you? ☐ Yes ☐ No

If yes, please provide the referring physician information:

Referring Physician Name ____________________ Phone No. (_____) ____________

Referring Physician Address ____________________

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 7)

***The above Statements are true to the best of my knowledge and belief.***

Printed Name of Physician ____________________ Phone No. (_____) ____________

Street Address ____________________ Specialty ____________

City ____________ State ________ ZIP Code __________

Signature of Physician ____________________ Date ______ /______/_________

- **Include the required medical documentation (listed on page 6) for the patient’s diagnosis or condition.**



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**For each condition below for which you are treating this patient, enclose the information listed under the Medical Documentation Requirements section.**

| **Illness** | **Medical documentation requirements:** |
|---|---|
| Heart attack | • Medical records from the emergency room and cardiologist<br>• EKG report(s)<br>• Cardiac enzymes levels<br>• Imaging studies<br>• Echo cardiogram(s) |
| Heart transplant | • Medical records from the transplant team<br>• Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human-to-human replacement of the whole heart |
| Stroke | • Medical records from the neurologist<br>• Neuroimaging report(s)<br>• Modified Rankin Scale results 90 days after stroke |
| Coronary artery bypass surgery | • Diagnosis of coronary heart disease made by angiography test(s) in which the recommended treatment plan includes a CABG. |
| Invasive cancer or malignant melanoma | • Pathologist's report |
| Carcinoma in situ | • Pathologist's report |
| Major organ transplant | • Medical records<br>• Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ |
| End stage renal disease | • Medical records from the nephrologist<br>• Proof of renal dialysis |
| Loss of speech | • Medical records from a neurologist<br>• Clinically-proven that the loss of ability to speak has continued without interruption for a period of at least six (6) consecutive months |
| Loss of vision | • Medical records from ophthalmologist; including refractions, visual acuity, and visual field<br>• Proof must document that the blindness was due to Accidental Injury or Sickness; and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis. |

## State Specific Fraud Warning Statements

**Humana:**

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

**Alabama**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Alaska, Delaware, Idaho, Maine, Maryland, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Virginia, Washington, West Virginia**

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

**Arkansas, Louisiana, Rhode Island**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Arizona**

For your protection Arizona law requires the following statement to appear on this form.  Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California**

For your protection California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

**District of Columbia**

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky, Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Maryland**

Any person who knowingly **or** willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly **or** willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Puerto Rico**

Any person who knowingly and with intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or fixed term imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.