# Health Screening Benefit Claim Form

This claim form can be used to request reimbursement for your Health Screening Benefits under your Critical Illness or Supplemental Health plan. You can either have your physician complete and sign the information below or attach documentation from the provider indicating the date of service, and the service provided (description or CPT code).

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 pages 3-4)

## Service Information:

Date services were rendered _____/_____/_____

*Please check all services provided below: The claim must be completed and signed by your physician or include an itemized billing from your provider that includes the date of service and service(s) provided (CPT codes).*

- ☐ Bone Marrow testing
- ☐ Chest X-ray
- ☐ Flexible Sigmoidoscopy
- ☐ Pap Smear
- ☐ Biopsy for Skin Cancer
- ☐ Lipid Panel
- ☐ CA 15-3 (for Breast Cancer)
- ☐ Serum Protein Electrophoresis
- ☐ CEA (Colon Cancer)
- ☐ Stress EKG
- ☐ PSA (Prostate Cancer)
- ☐ Stress Test (bike or treadmill)
- ☐ CA-125 (Ovarian Cancer)
- ☐ Colonoscopy
- ☐ Electrocardiogram (EKG)
- ☐ Mammography (including ultrasound)
- ☐ Oral Cancer Screening using ViziLite, OraTest or dental code D0431

**Hospital Indemnity Only**

- ☐ 3 Blood pressure readings in 14 days with health care practitioner attestation
- ☐ Blood Glucose Test
- ☐ A1C1 Test (Diabetes)
- ☐ Water Displacement Test (Obesity)
- ☐ Skin Caliper Test (Obesity)

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

_____ _____/_____/_____

Signature of Subscriber Date

## Member Information:

Is the claim for the: ☐ Subscriber ☐ Dependent

Subscriber's Name _____ Policy No._____

Mailing Address_____ Social Security No. _____

City _____State_____ ZIP Code_____ Date of Birth _____/_____/_____

Daytime Phone number (_____) _____

Would you like to receive a text or email when your claim is processed? ☐ Text (your carrier's standard messaging rates apply) ☐ Email

(If Text) Number to receive text (_____) _____Name of wireless carrier _____

(If Yes) Email Address to recieve message: _____

Do you have medical coverage with Humana? ☐ Yes ☐ No If yes, Medical ID No. _____

Claimant Name_____ Date of Birth _____/_____/_____

## Provider Information:

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

Street Address_____ Specialty _____

City _____ State _____ZIP Code_____

Signature of Physician _____ Date _____/_____/_____

Humana®

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

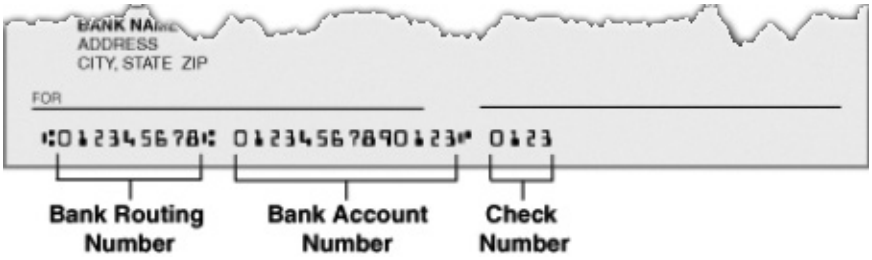
Customer Service: 1-855-448-6982
Or Fax to: 1-502-405-7107
Email to: vbclaimssubmission@humana.com

# Direct Deposit Authorization

| Check Action | | | Effective Date | | | Acct. Type | | Ownership of Account | | |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐☐ – ☐☐ – ☐☐☐☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| New | Change | Cancel | Month | Day | Year | Checking | Savings | Self | Joint | Other |

Bank Name _____

Bank Routing Number _____ Bank Account Number _____




I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize Kanawha Insurance Company to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ _____/_____/_____

Signature Date

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____ _____/_____/_____

Signature Date

**Terms And Conditions For Annuitants Participating In The Direct Deposit Program**

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by Kanawha Insurance Company, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify Kanawha Insurance Company of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE, and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be cancelled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to Kanawha Insurance Company or cannot be made to your account, Kanawha Insurance Company will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be cancelled by your financial institution or Kanawha Insurance Company. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**

Humana®

**Submit your claim:**
**Mail to the following address:**
**Humana**
P.O. Box 13068
Green Bay, WI 54344

**Or Fax to:** 1-502-405-7107
**Or Email to:** vbclaimssubmission@humana.com

# Health Screening Benefit Claim Form

**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.

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

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.

**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.

**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.

**Kansas:**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

**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.

# Health Screening Benefit Claim Form

**State Specific Fraud Warning Statements**

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.

Virginia:
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

## Discrimination is against the law

Humana Inc. and its subsidiaries comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide: (1) free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate; and (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-855-448-6982** or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-855-448-6982** or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**

## Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-855-448-6982 (TTY: 711)**.... ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-448-6982 (TTY: 711)**.... 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 **1-855-448-6982 (TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-448-6982 (TTY: 711)**.... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-448-6982 (TTY: 711)**번으로 전화해 주십시오.... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-448-6982 (TTY: 711)**.... Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-448-6982 (телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-855-448-6982 (TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-855-448-6982 (ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-855-448-6982 (TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-855-448-6982 (TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-855-448-6982 (TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-855-448-6982 (TTY: 711)**.... 注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-448-6982 (TTY: 711)**まで、お電話にてご連絡ください。... توجه: اگر ب زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید **1-855-448-6982 (TTY: 711)**.

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih **1-855-448-6982 (TTY: 711)**....

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لكبالمجان. اتصل برقم **1-855-448-6982 (رقم هاتف الصم والبكم: 711)**.