

## Critical Illness Claim Filing Instructions

### 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:

#### Kanawha Insurance Company

A Humana company  
P.O. Box 13068  
Green Bay, WI 54344

### Or FAX to:

1-502-405-7107

## Critical Illness Claim Form – Insured Statement

**Section I – General Information:**

Is the claim for the:  Policyholder  Dependent

Policyholder's Name \_\_\_\_\_ Policy No. \_\_\_\_\_

Street Address \_\_\_\_\_ Social Security No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Daytime Telephone No. (\_\_\_\_) \_\_\_\_\_

Do you have medical coverage with Humana?  Yes  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)

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

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Signature of Policyholder Date



**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 \_\_\_\_\_

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***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.**

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	<ul style="list-style-type: none"> <li>• Medical records from the emergency room and cardiologist</li> <li>• EKG report(s)</li> <li>• Cardiac enzymes levels</li> <li>• Imaging studies</li> <li>• Echo cardiogram(s)</li> </ul>
Heart transplant	<ul style="list-style-type: none"> <li>• Medical records from the transplant team</li> <li>• 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</li> </ul>
Stroke	<ul style="list-style-type: none"> <li>• Medical records from the neurologist</li> <li>• Neuroimaging report(s)</li> <li>• Modified Rankin Scale results 90 days after stroke</li> </ul>
Coronary artery bypass surgery	<ul style="list-style-type: none"> <li>• Operative report(s) from the cardiologist</li> <li>• Angiography report(s) from the cardiologist</li> </ul>
Invasive cancer or malignant melanoma	<ul style="list-style-type: none"> <li>• Pathologist's report</li> </ul>
Carcinoma in situ	<ul style="list-style-type: none"> <li>• Pathologist's report</li> </ul>
Major organ transplant	<ul style="list-style-type: none"> <li>• Medical records</li> <li>• 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</li> </ul>
End stage renal disease	<ul style="list-style-type: none"> <li>• Medical records from the nephrologist</li> <li>• Proof of renal dialysis</li> </ul>
Loss of speech	<ul style="list-style-type: none"> <li>• Medical records from a neurologist</li> <li>• Clinically-proven that the loss of ability to speak has continued without interruption for a period of at least six (6) consecutive months</li> </ul>
Loss of vision	<ul style="list-style-type: none"> <li>• Medical records from ophthalmologist; including refractions, visual acuity, and visual field</li> <li>• 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.</li> </ul>

## State Specific Fraud Warning Statements

### **Kanawha Insurance Company:**

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.

### **Arkansas, Louisiana, Maryland, 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.

### **California, New Jersey**

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, Ohio, 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.

### **New Mexico**

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 civil fines and criminal penalties.

### **North Carolina**

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

### **Oklahoma**

**WARNING:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

### **Oregon**

Any person who knowingly and with intent to defraud, commits a fraud against an insurer by submitting a claim containing an intentionally materially false or deceptive misstatement, misrepresentation, omission, or conceals any fact material to the interest of Humana, may have committed fraud which is a crime and which may result in the loss of coverage and/or denial of claim under this policy and may subject such person to prosecution for fraud, including criminal and civil penalties. Eligibility for coverage on this policy may be denied or rescinded under this provision without time limit in the event of fraud.

Beginning two years after the effective date of this policy no misstatements, except fraudulent misstatements, may be used to void this policy.

### **Tennessee, Virginia and Washington**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.