

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 provide the prior physician information:

Physician's Name	Address	Phone Number

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

If yes, Please provide 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*

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"> • Medical records from the emergency room and cardiologist • EKG report(s) • Cardiac enzymes levels • Imaging studies • Echo cardiogram(s)
Heart transplant	<ul style="list-style-type: none"> • Medical records from the transplant team • 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	<ul style="list-style-type: none"> • Medical records from the neurologist • Neuroimaging report(s) • Modified Rankin Scale results 90 days after stroke
Coronary artery bypass surgery	<ul style="list-style-type: none"> • Operative report(s) from the cardiologist • Angiography report(s) from the cardiologist
Invasive cancer or malignant melanoma	<ul style="list-style-type: none"> • Pathologist's report
Carcinoma in situ	<ul style="list-style-type: none"> • Pathologist's report
Major organ transplant	<ul style="list-style-type: none"> • Medical records • 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	<ul style="list-style-type: none"> • Medical records from the nephrologist • Proof of renal dialysis
Loss of speech	<ul style="list-style-type: none"> • Medical records from a neurologist • 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	<ul style="list-style-type: none"> • Medical records from ophthalmologist; including refractions, visual acuity, and visual field • 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

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, 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, 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.

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 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.