

Cancer Insurance Claim Form

Central States Health & Life Co. of Omaha

Administered by A.G.I.A., Inc.

PO Box 9060 Phoenix, AZ 85068-9060

Phone: 877-883-8800 • www.claimformassist.com/CSO

Certificate Number

(Found on your Schedule of Benefits)

To submit your claim, please complete all required fields and return this form to the address above.

Part 1

Should be completed by the patient or authorized representative. If guardianship or power of attorney has been executed, please attach certified copies of the official designation.

Part 1.d. MUST be signed and dated by the patient making the claim or an authorized representative.

Part 2

Should be completed by the patient. This is **ONLY** required if you've had coverage less than one year.

Part 3

Should be completed by your physician if needed. This is **ONLY** required if you've had your coverage for less than one year.

Documents required to be submitted with this claim form:

- The Patient's test results and/or pathology report.
- Copies of itemized medical bills which include the diagnosis, date of service, description of service or medical coding, and charged amount.
- If treatment was rendered through the Veteran's Administration, include admission/discharge paperwork and/or daily progress notes in place of an itemized bill.

Please **PRINT** clearly, and answer all questions as completely as possible. Unanswered questions could result in additional requests for information and require additional time in processing your claim. You may attach additional pages if space is limited on this form.

PART 1 – PATIENT STATEMENT – To be completed by the patient or authorized representative. All fields must be fully completed. Please be sure to sign and date the authorization.

1.a. PRIMARY INSURED'S INFORMATION

Legal name of member (first, middle, last)

Other names by which the member is known, if any

Date of birth (mo/day/yr)

Street Address

City

State

Zip

Day Time telephone number

Email address

Who is this claim for? ☐ Member ☐ Dependent Spouse/Domestic Partner/Child (If checked, please complete Part 1.b.)

1.b. DEPENDENT INFORMATION If the Dependent is the patient then complete the following Dependent Information:

Legal name of dependent

Other names by which the dependent is known, if any

Date of birth (mo/day/yr)

Street Address ☐ (check box if same as above)

City

State

Zip



PART 1 – PATIENT STATEMENT (Continued from Previous Page)

1.c. PATIENT INFORMATION

Describe condition or illness

Date symptoms first appeared (mo/day/yr)

Date first treated for this condition (mo/day/yr)

Date of diagnosis (mo/day/yr)

1.d. Authorization for Release of Health-Related Information to Central States Health & Life Co. of Omaha, administered by A.G.I.A., Inc. Authorization Complies with the HIPAA Privacy Rule.

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any medical professional, pharmacy benefit manager, psychologist, social worker, hospital (including Veterans Administration Hospital) clinic or other facility, insurance company, consumer reporting agency, employer, the Social Security Administration, Internal Revenue Service, coroner/medical examiner, police department or other organization or person which has any information on to give all such medical or nonmedical information to Central States Health & Life Co. of Omaha, administered by A.G.I.A., Inc. (Company) or its authorized representative. This shall include but not be limited to information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, and tests. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This authorization shall be valid for 24 months from the date it is signed. I have read it and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time except to the extent that the Company has taken action in reliance upon the authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by the Company. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

WARNING: Any person who knowingly, willfully, or with intent presents materially false, incomplete, misleading or fraudulent information for the purpose or intent of deceiving or defrauding an insurer is guilty of a crime and may be subject to imprisonment, fines, denial of insurance and civil penalties.

Signature of patient or authorized representative:

X _____

Date signed (MO/DAY/YR):

X _____

PART 2 – PATIENT STATEMENT

2.a. This is **ONLY** required if you've had your coverage for less than **ONE YEAR**

Please list the name and address of any physician or hospital that has treated you in the past three (3) years for **ANY** reason. If more than four physicians or hospitals, please attach a separate sheet.

Name of Primary Family Physician	Dates (Mo/Day/Yr)	Reason
Street Address	Telephone Number	
City	State	
	Zip	
Name of Physician	Dates (Mo/Day/Yr)	Reason
Street Address	Telephone Number	
City	State	
	Zip	
Name of Physician	Dates (Mo/Day/Yr)	Reason
Street Address	Telephone Number	
City	State	
	Zip	
Name of Hospital	Dates (Mo/Day/Yr)	Reason
Street Address	Telephone Number	
City	State	
	Zip	

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

PART 3 – ATTENDING PHYSICIAN'S STATEMENT

The below is **ONLY** Required if claim date of service is within **ONE YEAR** of Insured's effective date of coverage.

Cancer Insurance Claim – Attending Physician's Statement

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Certificate Number *(Should be completed by the insured or authorized representative)*

Please have the form below completed by the physician currently treating you for the medical condition which relates to this claim. All fields must be fully completed. The patient is responsible for all costs associated with the completion of this form.

3.a. PATIENT INFORMATION

Name of patient

Physician's reference/patient number

3.b. CURRENT CONDITION

Diagnosis (If more than one, please attach a separate sheet.)

Date of diagnosis

Subjective symptoms

Objective findings (including current x-rays, EKG's, laboratory data, and any clinical findings)

3.c. PATIENT HISTORY

When did symptoms first appear?

Has the patient ever had the same or a similar condition? ☐ Yes ☐ No
If yes, state when and describe below

Date of first visit (mo/day/yr)

Date of last visit (mo/day/yr)

Frequency of treatment ☐ Weekly ☐ Monthly ☐ Other (please specify)

Please list all current prescription medications

Has the patient received prior treatment from another physician? ☐ Yes ☐ No If yes, provide name and address below

Physician name

Physician address

Additional remarks

3.d. SIGNATURE OF ATTENDING PHYSICIAN

Print name of attending physician

Specialty

Telephone number

Physician's address (street, city, state, zip)

Print name of person completing this form

Signature of attending physician

Date signed (mo/day/yr)

X

X