PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-8354

#### INSTRUCTIONS FOR FILING A MEDICAL CLAIM CANCER TREATMENT

The forms must be completed by the claimant. All questions on the forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please return the requested information as soon as possible for prompt processing.

#### The claimant is responsible for this information without expense to the Company.

- The enclosed Statement of Claim should be fully completed by the primary insured and the
  patient. Please make sure the Authorization at the bottom of the page is signed and dated.
- The Physician's Statement of Claim should be completed by your primary treating physician.
- A **Pathology Report** showing a positive diagnosis of Cancer and the date it was made. This can be obtained from the physician.
- Itemized Hospital Bills: Please obtain from the hospital or outpatient facility the UB04 standard billing form or a detailed billing indicating line by line description of services and diagnosis.
- Itemized Physician Bills: Please obtain a HCFA1500 from the physicians for surgery, anesthesiology, and chemotherapy, radiation therapy. Itemized billings which provide us with the diagnosis, procedure codes, charges and service dates are also acceptable.
- **Primary Insurance EOBs:** If you have a primary insurance carrier which has paid on your claim, please include their explanation of benefits.
- The enclosed HIPAA form, Authorization Form for Disclosures of a Claimant's
- Protected Health Information should be fully completed by the patient.
- The enclosed Personal Representative HIPAA form, Authorization Form for
- Disclosures of a Claimant's Protected Health Information to Personal Representative should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current General Durable Power of Attorney in lieu of this form.
- Please DO NOT HIGHLIGHT your bills or forms.

\*\*\*If you send receipts, please send **photocopies**. It is possible for a claim to be lost or damaged in the mail and if the originals are sent you more than likely will not be able to get another copy.

If your condition was diagnosed within the first two (2) years of your policy's effective date, it is considered contestable. We may request medical records from the physicians who have treated you within the five (5) years prior to the policy effective date. Please make sure to provide a list of the full names, addresses and telephone numbers of all physicians who have treated you.

This instruction form and our requests for additional information should not be considered a guarantee that payment will be made. Please make sure all documentation requested is fully completed and returned to our office as soon as possible. If you have questions, please contact our Customer Service Department.

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-8354

### Statement of Claim - Individual Policy

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| o <b>you, yo</b> u | ur spous   | e, whether ma  | arned or divorced, or<br>nsurance coverage  |  |  |  |  | ••••   |  |   |
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| □ Spouse depender  |  | s over age 19,   | indicate:   | If full time s   | student, give name   | ☐ Female and address of :  |  |  | Claimant's occu  | ipation:  |
| ⊐ Self             |  | Child  | Olaman S Hame E   |  | The Ristream   | □ Male   |  |  | Olds Hatt 5 date   | or on un.   |
| laim is for        |  | ,  | Claimant's name a   | and SSN (if  | ☐ Married ☐  | ☐ Widowed<br>Sex of claims   | ant:   |  | Claimant's date  | of hirth:   |
| nsured's d         | ate of bit   | rth:   | Social Security No  | r.;  | Marital Status: ☐ Single □   | ☐ Divorced   | Employ   | er's name 8  | address:   |   |
|                    |  | -  | Phone: (  | )  |  |  | your at  | idress has<br>ed   |  |   |
| nsured's n         | ame:   |  | Insured's addr  | ess:   |  |  | 4  |  | Policy/Certificat  | te No.  |

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-6354, FAX 1-580-255-0951

## ATTENDING PHYSICIAN'S STATEMENT OF CLAIM

| 10 BE FULLY CUMPLETED BY YOUR PRIMAR   | Y TREATING PHYSICIAN.            | - Control of the Cont |
|--|----------------------------------|--|
| SESTION (IT TEAT AND & INSURED (STESCRIBER) IN<br>1. PATIENT'S NAME (First, middle initia), last nam 2. PA   | DRAWFION                         | 2 INCLUDITY NAME (C. )   |
| C. PACCES O NAME (FILST, BIDDIE INDIA), ISSUITATI Z. PA  | HEN IS DATE OF BIRTH             | 3. INSURED'S NAME (First, middle initial, last name)   |
|  |                                  | ***************************************  |
| 4. PATIENT'S ADDRESS (Street, city, state, zip) 5. PAT   | TIENT'S SEX                      | 6. INSURED'S ID # or MEDICARE # (include any letters)  |
|  | -                                |  |
|  | ☐ MALE ☐ FEMALE                  |  |
| 7. INS   | URED'S SOCIAL SECURITY#          | 8. INSURED'S POLICY#   |
|  |                                  |  |
|  |                                  |  |
| 9. DATE FIRST CONSULTED FOR THIS CONDIT 10, DA   |                                  | 10. WAS PATIENT TREATED BY ANOTHER PHYSICAN(S),  |
|  |                                  | PRIOR TO YOUR TREATMENT  |
|  |                                  | C YES  |
| 11. DATE SYMPTOMS FIRST APPEARED   | -                                |  |
|  |                                  | If 'YES', PROVIDE NAME & ADDRESS OF ALL PHYSICIAM'S KNOWN  |
| 12. HAS PATIENT EVER HAD SAME OR SIMILAR SYM   | (CTCOMO                          | ·  |
| TENSORALISM EVER HAD SAME OR SIMILAR STM   | PTOMS                            | <del></del>  |
|  |                                  |  |
| IF YES, PROVIDE DETAILS INCLUDING DATES OF T   | REATMENT AND DIAGNOSIS           |  |
| •  |                                  |  |
|  |                                  |  |
|  |                                  |  |
|  |                                  | 13. IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE   |
| 14. IS CONDITION DUE TO AN ACCIDENT? TYES  | EJ NO                            | PROVIDE NAME, ADDRESS OF PHYSICIAN, DATE OF REFERRAL   |
| 1110 0011011011010101111111111111111111  |                                  |  |
|  |                                  |  |
| 15. IF YES, HOW DID ACCIDENT HAPPEN?   | •                                |  |
|  |                                  |  |
|  |                                  | Date of Referral:  |
| 16. NAME & ADDRESS OF FACILITY WHERE SERVICE   | C DEADED G                       | AT OR VOLUMEN LOOPER LO |
| 10. WHILE GROOMESS OF PACIFIC WHERE SERVICE  | 23 KENDERED (II NOT HORSE OF DIS | THE YES INO  |
|  |                                  |  |
| PF-04-4  |                                  | 18. FOR SERVICES RELATED TO HOSPITALIZATION,   |
| }-   |                                  | NAME & ADDRESS OF FACILITY   |
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| and the same of th |                                  |  |
|  |                                  | DATE ADMITTED DATE DISCHARGED  |
| The state of the s | · · · · ·                        | DOTTE MICOLANIA WALL   |
|  |                                  |  |
| 19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   |                                  |  |
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| 1. <u> </u>  |                                  |  |
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| 3.   |                                  |  |
| 4_   |                                  |  |
| 5.   |                                  |  |
| 3.   |                                  | waterunia  |
| 20. SIGNATURE OF PHYSICIAN OR SUPPLIER   | 21. YOUR SSN                     | 22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #  |
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| <del></del>  |                                  |  |
| DATE   | 23. YOUR TAX ID #                |  |
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PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-8354

#### AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

- I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.
- 2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.
- 3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.
- 4. This authorization will expire twenty-four (24) months from the date the authorization is signed.
- 5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization
- 6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.
- 7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.
- 8. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

| If you are the representative of the claimant, describe the scope of your authority to act on the claimant's beh | alf: |
|--|------|
|  |      |
|  |      |
| Claimant   |      |
| Name   |      |
| Name and relationship of claimant's Personal representative, if applicable                                       |      |
| Signature of claimant (or claimant's representative)   |      |
| Date of claimant's (or claimant's representative) signature  |      |
| Date of claimant's (or claimant's representative) signature  |      |

A signed copy of this form will be provided any time upon request.



# AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by Loyal American Life Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

| name                             | relationship  | address             |                    | date of birth            | social security#        |
|----------------------------------|---|---------------------|--------------------|--------------------------|-------------------------|
| name                             | relationship  | address             |                    | date of birth            | social security #       |
| name                             | relationship  | address             | •                  | date of birth            | social security #       |
| Describe fully trepresentative(s | the protected health informa<br>s).   | tion that is NO     | allowed to be      | disclosed to the abo     | ve named personal       |
|                                  |   |                     |                    |                          |                         |
| health plan cove                 | at if the person or entity that<br>ered by the federal privacy re<br>ger be protected by the federa | gulations, the in   | formation may be   |                          |                         |
| writing at any fir               | the Notice of Privacy Pract<br>me, except to the extent that<br>n revocation to the Company         | action has been     | taken by the Cor   | npany in reliance on t   | this authorization, by  |
|                                  | on will expire upon the earlies a. the following date: b. twenty-four (24) months                   | <del>-</del>        |                    | ; or igned.              |                         |
|                                  | at I am not required to sign the  |                     | orm and that the 0 | Company will not cond    | lition the provision of |
|                                  | at a photocopy, facsimile co<br>lid as the original.  | opy, or other ele   | ectronic copy of t | this authorization sha   | all be considered as    |
| I understand tha                 | at I or my personal representa  | tive am entitled to | o receive a copy o | of this authorization up | on request.             |
| Insured Name                     | ······································  |                     | Name of perso      | nal representative, if   | applicable              |
| Signature of Ins                 | ured (or Insured's representa   | ive)                | Relationship o     | f personal representat   | ive to Insured          |
| Date of Insured's                | s (or Insured's Representative  | e's) Signature      | Insured Policy     | Number(s)                |                         |

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HIPAA 0049b (2-28-03)

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-8354 Fax: 1-580-255-0951

#### **Transportation Verification Form**

| Policy Number   | Name of Patient   |                                 |                 | Male<br>Female                          | Date of Birth                              |
|---|---|---------------------------------|-----------------|---|--|
| Name and Addres                                       | s of Primary Insured  |                                 | Male<br>Female  | Date of Birth                           |  |
|   |   |                                 | Social Sec      |   | Telephone                                  |
|   |   |                                 |                 | •                                       |  |
|   |   | ·                               | 1               |   | ( )  |
| Spouse's Name _                                       |   |                                 | <u> </u>        |   |  |
| Travel by:  | ☐ Airline ☐ Railroad (Attach copy of airline, railroad or bus tick                        | ☐ Bus                           |                 | [ Private Au                            | tomobile                                   |
| I HEREBY CERTIL<br>traveled to or from                | FY THAT (patient's name) a hospital for treatment of cancer or                            | the following dates:            | - Acaron Joseph |   |  |
| DATE  | MILEAGE   | FROM                            |                 |   | TO   |
|   | (If roundtrip, show total miles)  | <u>IKOM</u>                     |                 | (Name and a                             | ddress of institution providing treatment) |
| -   |   | •                               | -               | *************************************** |  |
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| DIAGNOSIS   |   |                                 | ···             |   |  |
| TYPE OF TREATM  | ENT RECEIVED:   |                                 |                 |   |  |
| THE OF THE STAR                                       |   |                                 | ٠.              |   |  |
| If not, where is the                                  | t available in the city where the patie<br>nearest hospital where the treatmer            | nt could have been render       |                 | l No                                    |  |
| City and State;                                       | MANANTA   | <u>.</u> .                      |                 |   |  |
| Signed: x   |   | Date:                           |                 |   |  |
| Printed:  | Physician's Signature   |                                 |                 |   |  |
| Name, A   | address and Telephone Number  |                                 |                 |   |  |
|   | n who knowingly, and with intent to injure, or false, Incomplete or misleading informatio |                                 | makes any d     | laim for the pr                         | oceeds of an insurance                     |
| I further certifiy that I hat this page that micht ap | ave read and understand the above Fraud War<br>ply to me or my family.                    | ming Statement and the addition | nal Fraud Wan   | ning Statement                          | s that appear on the back of               |
| x   |   | Date:                           |                 |   |  |
| Insu  | red's Signature   |                                 |                 | ,                                       | ***************************************    |

The law in ALASKA states: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony."

For your protection the law in ARIZONA states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal penalties."

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604 Phone (800) 366-8354

#### FRAUD WARNING STATEMENTS

The law in ALASKA states: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony."

For your protection the law in **ARIZONA** states: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal penalties.

The law in **ARKANSAS** states:" 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."

For your protection the law in **CALIFORNIA** states: "Any person who knowingly presents a 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."

The law in **COLORADO** states: "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

companywhoknowinglyprovidesfalse,incomplete,ormisleadingfactsorinformationtoapolicyholderorclaimantforthepurposeofdefraud ingorattemptingtodefraudthepolicyholderorclaimantwhregardtoasettlementorawardpaymentfrominsuranceproceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DELAWARE** states: "A person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

The law in **FLORIDA** states: "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."

The law in **IDAHO** states: "Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony."

The law in **INDIANA** states:" A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

The law in **LOUISIANA** states: "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."

The law in **MAINE** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits."

The law in MINNESOTA states: "A person, who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime."

The law in **NEWJERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "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 a and criminal penalties."

The law in **OHIO** states: "Any person who, with 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 is guilty of insurance fraud."

The law in **OKLAHOMA** states: "**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."

The law in **PENNSYLVANIA** states: "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."

The law in **TEXAS** states: "Any person who knowingly presents a 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."

The law in **VIRGINIA** states: "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 state law."