Humana Insurance Company Cancer Claim Filing Instructions H.E.B. Partners

How to file your first claim:

- 1. For all claims, complete each section of the claim form and sign and date where indicated.
- For cancer diagnosis claims, include with the claim form the <u>pathology report(s)</u> verifying the <u>positive</u> <u>diagnosis</u> of cancer. Be sure to attach the earliest diagnosis of cancer to ensure proper payment of benefits.

Itemized medical bills/statements

Please obtain itemized medical bills from your medical providers. The medical bills must include the diagnosis code, list each service provided including the dates of service and actual charges. We are unable to process benefits from account summaries/balance due statements.

Deadline to submit losses/expenses:

All claim documentation must be received within 15 months from the date the loss/expense is incurred.

3. Please submit the completed claim form and all documentation by mail or fax to:

Humana Claims Bay Bridge Administrators L.L.C. PO Box 161690 Austin TX 78716 512-275-9350 (Fax)

Submitting Additional Claims:

The Insured does not need to fill out a claim form each time, please include the insured's name and claim number when submitting additional claim documentation.

Example: John Doe- Claim No: Attn: Humana Cancer Claims

Notification:

If you have questions or need assistance, please call us toll free at 1-800-845-7519 and ask to speak with a claims examiner about your claim. *8AM-5PM, Central Time, Monday-Friday*

Claim Form for Cancer Cov	verage				oy: Bay Br PO Bo Austin	rance Company idge Administrators, L.L.C. x 161690 TX 78716 45-7519
INSURED'S STATEMENT OF CLAIM TO BE COMPLETED POLICYHOLDER						
Name of Insured						icate Number
Street Address			City		State	Zip Code
Phone Number (Area Code First)				Insured's Date of Birth		
Name of Claimant		Relationship to Insured			Claimant's Date of Birth	
Type of Illness for which claim is being n	nade			Date of First Diagnosis		
Describe the onset and nature of your illr	less.					
Date you were first	Treated by	<i>r</i> :				
treated for your illness	Hospital: _	Name			Address	
Date	Doctor: _	Name			Address	
Have you ever had the same or a similar	Treated by	7:				
condition in the past?	Hospital:	Name			Address	
YesNo	Doctor:					
Date		Name			Address	
Any person who knowingl knowingly presents false i subject to fines and confin The above Statements are true	nformat ement i	ion in an a n prison.	pplicat	ion for insurance		
Signature of Insured				Date		

Return fully completed claim form and supporting documentation by mail or fax to: Bay Bridge Administrators, L.L.C. PO Box 161690 Austin TX 78716 512-275-9350 (fax

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

- 1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
- 2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.
- 3. I authorize only designated staff of Bay Bridge Administrators, L.L.C. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
- 4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
- 5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, L.L.C. This revocation shall become effective on the date it is received by Bay Bridge Administrators, L.L.C. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
- 6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

Cianatana	Duint Mana	Data	
Signature	Print Name	Date	

I have legal authority* under the laws of the State of_to make health care decisions on behalf of______, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

Name of Authorized RepresentativeRelationship to ApplicantDateParent or Guardian*A copy of the legal authority document must be on file with BayBridge Administrators, L.L.C.

If claim is being filed during the first year of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last year:

Physician's Name: Address:

 Telephone Number:

 Approximate Date Consulted:

 Diagnosis:

Physician's Name: Address: Telephone Number: Fax Number: Approximate Date Consulted: Diagnosis: Physician's Name: Address:

 Telephone Number:
 Fax Number:

 Approximate Date Consulted:
 Diagnosis:

Diagnosis:____ Physician's Name: Address: Fax Number: Telephone Number: Approximate Date Consulted: Diagnosis: Please list all prescribed medications now being taken by patient: Prescribing Doctor Date First Prescribed Name of Medication _____ Any person who, with 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 is subject to prosecution and punishment for insurance fraud. ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

State Specific Fraud Warning Statements

Arkansas

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

For your protection, California law requires the following 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 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

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.

Louisiana

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.

Maryland

Any person who knowingly and willfully 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.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject 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.

Ohio

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.

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.

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.

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.

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.