

**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.
2. For cancer diagnosis claims, include with the claim form the **pathology report(s)** verifying the **positive diagnosis** 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 Coverage	<b>Humana Insurance Company</b> <b>Administered by: Bay Bridge Administrators, L.L.C.</b> <b>PO Box 161690</b> <b>Austin TX 78716</b> <b>800-845-7519</b>
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<b>INSURED'S STATEMENT OF CLAIM</b>	<b>TO BE COMPLETED BY POLICYHOLDER</b>
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Name of Insured	Policy/Certificate Number
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Street Address	City	State	Zip Code
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Phone Number (Area Code First)	Insured's Date of Birth
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Name of Claimant	Relationship to Insured	Claimant's Date of Birth
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Type of Illness for which claim is being made	Date of First Diagnosis
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Describe the onset and nature of your illness.

Date you were first treated for your illness  _____ Date	Treated by:
	Hospital: _____ Name Address
	Doctor: _____ Name Address

Have you ever had the same or a similar condition in the past?  __Yes __No  _____ Date	Treated by:
	Hospital: _____ Name Address
	Doctor: _____ Name Address

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

\_\_\_\_\_  
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)**



**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: \_\_\_\_\_ Fax 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: \_\_\_\_\_

Physician's Name:

Address:

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Approximate Date Consulted: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 UNNECESSARY 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 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

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.