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Mutual of Omaha Affiliates

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A Guide for Successfully Completing the Group Critical Illness/Specified Disease Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group critical illness/specified disease benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed. All parts of this form are to be completed without expense to the underwriting company.

- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.
- Please use the Group Health Benefit Screening Claim Form for all health screening benefit claims.
- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.

Required Fraud Warnings
Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Guidelines for Section 1: Employee/Member, Patient & Claimant Statement
This section is to be completed by the Employee/Member. Dates should include month, date and year. In order to be considered complete, the form must be signed by you.

Guidelines for Section 2: Physician, Hospital and Medication Information
This section is required if this claim is being filed within the first year following the effective date of insurance for the Patient.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer
Both authorizations are to be completed by the Employee. Dates should include the month, date and year.

Guidelines for Section 3: Policyholder/Employer Statement
This section is to be completed by the policyholder/employer. In order to be considered complete, the form must be signed by the policyholder/employer.

Guidelines for Section 4: Attending Physician Statement
This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Fraud Warnings

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas and 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.

California: For your protection California law requires the following to appear on this form. 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.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine: 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 a denial of insurance benefits.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information 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 APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: 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 guilty of insurance fraud.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

Texas: 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.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Group Critical Illness/Specified Disease Claim Form

Employer Information

Policyholder/Employer Name

Group ID Number
G000 ___ ___ ___ ___

City

State

ZIP Code

Employee/Claimant Information

Employee Name (First, MI, Last)

Employee Date of Birth (MM/DD/YYYY)

Employee SSN

Employee Street Address

Employee City

Employee State

Employee ZIP Code

Employee Email Address

Employee Phone Number

Preferred method of Contact (Emailed/Phone Call)

Employee Gender
❑ Male ❑ Female

Smoker or Non-Smoker

Employee Marital Status
❑ Single ❑ Married/Partnered ❑ Widowed ❑ Divorced

Patient/Claimant Information – Only complete this section if the Patient is not the Employee

Patient Name (First, MI, Last)

Patient Street Address

Patient City

Patient State

Patient ZIP Code

Patient Date of Birth (MM/DD/YYYY)

Patient Gender
❑ Male ❑ Female

Patient SSN or ID Number

Patient Relationship to Employee/Member

If the Patient is the Child of the Employee/Member, if over age 18, is the Child a Full-Time Student? ❑ Yes† ❑ No

If the Patient is the Child of the Employee/Member, is the Child married or in a partnership? ❑ Yes ❑ No

Eligibility Information (Only applicable for CA, DC, MA, NJ and NY)

Does the Employee/Member and the Patient (if not the Employee/Member) have Major Medical Insurance, or a combination of Basic Hospital and Basic Medical Insurance? ❑ Yes* ❑ No

*If Yes, provide name of insurance carrier and policy number for the Employee/Member and the Patient (if different):

Please check the Illness/Procedure for which this Claim is being filed. The Illness/Procedure selected must be included in your Certificate for the Claim to be considered. Refer to the Definitions in your Certificate for additional information, if needed.

❑ Heart Attack (Myocardial Infarction)
❑ Heart Transplant/Placement on UNOS List
❑ Heart Valve Surgery
❑ Coronary Artery Bypass
❑ Aortic Surgery
❑ Stroke
❑ Major Organ Transplant/Placement on UNOS List
❑ End-Stage Renal Failure
❑ Acute Respiratory Distress Syndrome (ARDS)
❑ Cancer (Invasive)
❑ Bone Marrow Transplant
❑ Carcinoma in Situ
❑ Benign Brain Tumor
❑ Skin Cancer
❑ Cerebral Palsy (children only)
❑ Structural Congenital Defect(s) (children only)
❑ Genetic Disorder(s) (children only)
❑ Congenital Metabolic Disorder(s) (children only)
❑ Type 1 Diabetes (children only)
❑ ALS (Lou Gehrig's) Disease
❑ Advanced Alzheimer's Disease
❑ Advanced Parkinson's Disease

Date the Patient was diagnosed with the illness or need for the procedure, or the date the procedure was performed (MM/DD/YYYY):

Briefly describe the illness or procedure:

Has the Patient ever had the same or similar illness/procedure? ❑ Yes* ❑ No

*If Yes, provide the date of prior illness/procedure and date of last treatment (MM/DD/YYYY):

Has a benefit ever been paid for the Patient under any other Critical Illness/Specified Disease Policy sponsored by the Policyholder/Employer? ❑ Yes† ❑ No

†If Yes, provide the date (MM/DD/YYYY) and amount of each benefit:

If the Patient was hospitalized for the Illness/Procedure stated above, provide hospital information:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason for Visit/Care

Provide information for any other hospital at which the Patient received care for the Illness/Procedure:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason for Visit/Care

Provide information for the Patient's Primary Care Physician (Ex. Family Doctor or Pediatrician):

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

Provide information for the Patient's Attending or Treating Physician/Specialist for the Illness/Procedure stated in Section 4:

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

If the Patient was treated at more than two hospitals or by more than two physicians, provide the information required above for each hospital or physician on a separate sheet of paper and submit it with this claim.

Who is the Claimant (the person filing this claim)? ❑ Employee/Member ❑ Spouse/Partner ❑ Beneficiary ❑ Other** (Ex. Power of Attorney, Conservator)

COMPLETE THE FOLLOWING ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER

Claimant Last Name | Claimant First Name | Claimant MI | Claimant Email Address

Claimant Street Address | Claimant City | Claimant State | Claimant ZIP Code

Claimant Date of Birth (MM/DD/YYYY) | Claimant SSN or ID Number | Claimant Home Phone Number | Claimant Cell Phone Number

If applicable, relationship to Employee/Member | If applicable, type of Legal Representative

****If other, such as power of attorney or conservator, a copy of the document granting authority must be submitted with this claim.****

Physician, Hospital and Medication Information

Employee/Member Name | Employee/Member SSN or ID Number | Group ID Number G000 ___ ___ ___ ___

Patient Name (If not the Employee/Member) | Patient SSN or ID Number (If not the Employee/Member)

Patient Date of Birth (MM/DD/YYYY) | Patient Gender ❑ Male ❑ Female | Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)

If the Patient was hospitalized within the year prior to the effective date of insurance for the Patient, provide the following:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason for Visit/Care

Provide information for any other hospital at which the Patient was hospitalized within the year prior to the effective date of insurance for the Patient:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason For Visit/Care

If the Patient was treated at more than two hospitals, provide the information required above for each additional hospital on a separate sheet of paper and submit it with this form.

If the Patient was treated by any physician within the year prior to the effective date of insurance for the Patient, provide physician information:

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

Provide information for any other physician from whom the Patient received treatment within the year prior to the effective date of insurance for the Patient:

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

If the Patient was treated by more than two physicians, provide the information required above for each additional physician on a separate sheet of paper and submit it with this form.

List any over-the-counter drugs, prescription drugs or medication taken by the Patient for any reason within the year prior to the effective date of insurance for the Patient:

Name of Drug/Medicine	Date(s) Taken	Pharmacy Name, Phone, City & State	Prescribing Physician Name

If there are additional drugs/medicines to be listed, provide the information requried above for each additional drug/medicine on a separate sheet of paper and submit it with this form.

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.

Signature of Claimant | Date

Signature of Patient, if age 18 or older (and not the Claimant) | Date

❑ Check here if Patient is deceased or incapable of signing.

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   ATTN: Group Critical Illness/Specified Disease Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1835 or Email: submitgrpci@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative_____

Signature of Legal Representative_____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the critical illness/specified disease program provided under my Group critical illness/specified disease policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing critical illness/specified disease benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Critical Illness/Specified Disease Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Or

Fax 402-997-1835

Or

Email submitgrpci@mutualofomaha.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

_____

(Printed Name and Address)

_____ _____

Signature Date

Or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

Date_____

RETAIN A SIGNED COPY FOR YOUR RECORDS

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Policyholder/Employer Statement

Employee/Member Name | Employee/Member SSN or ID Number

Patient Name (If not the Employee/Member) | Patient SSN or ID Number (If not the Employee/Member)

Patient Date of Birth (MM/DD/YYYY) | Patient Gender ❑ Male ❑ Female | Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)

Policyholder/Employer Name | Group ID Number G000 ___ ___ ___ ___

City | State | ZIP Code

Email Address | Phone Number | Fax Number

Effective Date of Insurance for Employee/Member (MM/DD/YYYY)

Employee/Member Benefit Amount (Elected/In Effect) | Patient benefit amount (Elected/In Effect, if applicable)

Was the Employee/Member or Patient previously insured under any other Critical Illness insurance policy offered through the Policyholder/Employer? ❑ Yes ❑ No

****A Copy of the Employee/Member's enrollment form/record and current beneficiary designation must be submitted with this claim.****

Class | Full-Time Employment Date (MM/DD/YYYY) | Avg. Hours Worked/Week

Does the Employee pay any premium for this insurance? ❑ Yes* ❑ No

*If Yes, what % of total premium is paid pre-tax by the Employee? _____% Pre-Tax

If the Employee is no longer working the minimum hours required under the policy, indicate why:

❑ Termination ❑ Layoff ❑ Personal Leave of Absence ❑ Medical Leave of Absence (e.g., FMLA) ❑ Other (Explain):

Use this space to provide any additional information related to the information stated above, as needed:

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.

Signature of Policyholder/Employer Representative | Date

Printed Name | Title

Email Address | Phone Number | Fax Number

Attending Physician Statement

Employee/Member Name | Employee/Member SSN or ID Number | Group ID Number G000 ___ ___ ___ ___

Patient Name (If not the Employee/Member) | Patient SSN or ID Number (If not the Employee/Member)

Patient Date of Birth (MM/DD/YYYY) | Patient Gender ❑ Male ❑ Female | Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)

Please check the illness/procedure for which this claim is being filed, and submit any relevant test results, hospital discharge summary and/or your detailed medical statements/records with this form, in addition to information indicated below:

Illness/Procedure	Medical Documentation (As Applicable)	Additional Information	
❑ Heart Attack (Myocardial Infarction)	EKG, cardiac enzymes, biochemical markers, thallium scan, MUGA scan, echocardiogram, cardiac catheterization	Troponin T Level	Troponin I Level
❑ Heart Transplant/Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the Patient on the UNOS list? ❑ Yes ❑ No If Yes, provide date added to list:	
❑ Heart Valve Surgery	EKG, X-ray, echocardiogram, cardiac catheterization, MRI, surgical report (open surgery required)		
❑ Coronary Artery Bypass	Angiogram, electrocardiogram (EKG), echocardiogram, stress test, EBCT, surgical report (open surgery required)		
❑ Aortic Surgery	Angiogram, CT, MRI, surgical report (open surgery required)		
❑ Stroke	Neuroimaging studies, documented neurological deficits	mRS Level:	
❑ Major Organ Transplant/ Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the Patient on the UNOS list? ❑ Yes ❑ No If Yes, provide date added to list:	
❑ End-Stage Renal Failure	Proof of regular dialysis	Does the patient have chronic, irreversible failure of both kidneys to function? ❑ Yes ❑ No Does the Patient require dialysis at least weekly? ❑ Yes ❑ No	
❑ Acute Respiratory Distress Syndrome (ARDS)	Arterial blood gas, X-ray, ARDS definition satisfied using the AECC, Murray LIS, Delphi or Oxygenation Index (OI) methods	P/F Ratio:	OI:
		PCWP:	Murray LIS:
❑ Cancer (Invasive)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Rai or Binet Stage:
		Clark Level:	Breslow Thickness:
❑ Carcinoma in Situ	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Rai or Binet Stage:
		Clark Level:	Breslow Thickness:
❑ Skin Cancer (Basal or squamous cell carcinoma)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	
❑ Bone Marrow Transplant	Surgical report, proof of listing with NMDP		
❑ Benign Brain Tumor	Pathology report, CT, MRI, angiogram, MRA, surgery report		
❑ ALS (Lou Gehrig's) Disease	EMG NCV, X-ray, MRI, blood and urine studies, spinal tap, myelogram, neurological examination, muscle and/or nerve biopsy		
❑ Advanced Alzheimer's Disease	CT, MRI, PET, CSF, neurological examination	FAST Stage:	MMSE Score:
❑ Advanced Parkinson's Disease	CT, MRI, PET, neurological examination	Stage:	
❑ Cerebral Palsy (children only)	Formal diagnosis after age of 18 months		
❑ Structural Congenital Defect(s) (children only)	Diagnostic tests, clinical diagnosis		
❑ Genetic Disorder(s) (children only)	Genetic tests, clinical diagnosis		
❑ Congenital Metabolic Disorder(s) (children only)	GC/MS, blood tests, clinical diagnosis		
❑ Type 1 Diabetes (children only)	Blood tests, clinical diagnosis		

Diagnosis

ICD-9/10 Code | Date of Diagnosis (MM/DD/YYYY) | Date First Consulted (MM/DD/YYYY)

Was Surgery Performed? ❑ Yes* ❑ No | *If Yes, provide CPT 4 codes: | *Date Surgery Performed (MM/DD/YYYY)

Has the Patient ever had the same or similar illness(es)/procedure(s)? ❑ Yes† ❑ No ❑ Unknown | Is the Patient still under your care? ❑ Yes ❑ No‡ | ‡If No, final date of treatment (MM/DD/YYYY):

†If Yes, provide the date of prior illness(es)/procedure(s) and/or date of last treatment (MM/DD/YYYY):

Attending Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

Medical Specialty | Degree | Board Certification(s)

Tax ID Number | Are you (the Attending Physician) related to the Patient? ❑ Yes* ❑ No | *If Yes, explain the relationship:

If the Patient was hospitalized for the Illness/Procedure stated above, provide hospital information:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason for Visit/Care

Provide information for any other hospital at which the Patient received care for the Illness/Procedure stated above:

Hospital Name | Hospital Phone Number | Hospital Fax Number

Hospital Street Address | Hospital City | Hospital State | Hospital ZIP Code

Date of Admission (MM/DD/YYYY) | Date of Discharge (MM/DD/YYYY) | Reason for Visit/Care

Provide information for the Patient's Primary Care Physician (Ex. Family Doctor or Pediatrician):

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

Medical Specialty | Degree | Board Certification(s)

Provide information for any other treating Physician/Specialist for the Patient for the Illness/Procedure stated above:

Physician Name | Physician Phone Number | Physician Fax Number

Physician Street Address | Physician City | Physician State | Physician ZIP Code

Reason for Care

Medical Specialty | Degree | Board Certification(s)

If the Patient was treated at more than two hospitals or by more than two additional physicians, provide the information required above for each hospital or physician either below or on a separate sheet of paper and submit it with this claim.

Use this space to provide any additional information related to the information stated above, as needed:

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.

Signature of Attending Physician | Date