

Humana Insurance Company
Accident, Sickness, Heart Attack/Heart Disease/Stroke
Claim Filing Instructions

Page 1 – Insured’s Statement of Claim:

- Must be completed each time you file a claim.
- Be sure to answer every question.
- If filing a claim due to accident/injury where a police report was filed, a copy of the police report must be included with claim.

Page 2 – Authorization

- Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to Bay Bridge Administrators, L.L.C.

Page 3 – Pre-existing Investigation Form

- If claim is being filed within the first year of the policy and is for an illness, please complete this page with all physicians seen or medications taken in the past 12 months.
- If provider fax numbers are known, please provide them in order to expedite this process.
- Please make certain authorization is signed and dated.

Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation by mail or fax to:

Humana Claims
Bay Bridge Administrators, L.L.C.
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

Claim Form for Accident, Heart Attack/Heart Disease & Stroke	Humana Insurance Company Administered by: Bay Bridge Administrators, L.L.C PO Box 161690 Austin TX 78716 800-845-7519
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INSURED'S STATEMENT OF CLAIM

TO BE COMPLETED BY POLICYHOLDER

Name of Insured		Policy Number	
Street Address		Policy Number	
Phone Number (Area Code First)	City	State	Zip Code
Name of Claimant		Insured's Date of Birth	
Illness or Injury for which claim is being made	Relationship to Insured	Claimant's Date of Birth	
Describe the onset and nature of your illness or injury		Date of Accident or Date Illness was First Diagnosed	
Date you were first treated for your illness or injury: _____			
Date _____			

Have you ever had the same or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____	Treated by: Hospital: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Name Address </div> Doctor: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Name Address </div>
	Treated by: Hospital: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Address </div>
	Doctor: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Name Address </div>

Only complete the following portion if covered by and applying for Disability benefits under the optional rider on the Accident Policy

6. Between what dates were you totally and continuously disabled? From _____, 20____ to _____, 20____
7. Between what dates were you partially disabled? From _____, 20____ to _____, 20____
8. If still disabled, when do expect to resume full duties? _____

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 _____	_____

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: _____

Physician's Name:

Address:

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

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.

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Employer's Statement**Humana Insurance Company**

To be completed by Employer		
Employee's Name	SSN:	Date of Birth:
Occupation:	Date of Hire:	
Date last worked: _____	Has Employee returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for stopping work: _____ _____	If yes, full-time date _____ Part-time date _____	
Is employee's job being held open?		
Name and Address of Employer		
Employer Signature	Date Signed	
Printed Name and Title	Employer's Telephone Number	
E-mail address	Fax Number	

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Physician's Statement

To be completed by the Medical Provider		
Claimant Name	Date of Birth	
Diagnosis	ICD-9 Code	Date of Diagnosis
Date Disability Commenced ___/___/___		
Is condition due to injury or sickness arising out of patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Dates of Treatment Date of first visit ___/___/___ Date of last visit ___/___/___	Frequency of treatment Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other
Has patient been hospital confined for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list name of hospital and dates:		
Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, Diagnosis:	Dates of Treatment	Name and address of Referring Physician:
Nature of Treatment – please describe course of treatment:		
Progress: (a) prognosis with reasonable estimate of return to work date		
Medical Provider's Name (Please Print)	Phone Number	Fax Number
Limitations (what the patient CANNOT do)		

Physical Impairment *as defined in Federal Dictionary of Occupational Titles)	<input type="checkbox"/> Class I – No limitation of functional capacity; capable of heavy work *no restrictions (0-10%) <input type="checkbox"/> Class 2 – Medium manual activity *(15-30%) <input type="checkbox"/> Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%) <input type="checkbox"/> Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%) <input type="checkbox"/> Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)	
Remarks:		
Medical Provider's Signature	Date Signed	
Name of Physician (Please Print)	Telephone Number	Fax Number
Mailing Address		

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