# Humana Insurance Company
# Cancer, Specified Disease and Intensive Care Coverage
# Claim Filing Instructions

## How to file your first claim:

1. Complete each section of the first page of the claim form.
2. Attach a copy of the **pathology report(s)** with a **positive diagnosis** of cancer or a specified disease. Be sure to attach the earliest diagnosis of cancer or specified disease to ensure proper payment of benefits.
3. **For Intensive Care Coverage claims only – please complete each section of the first page of the claim form and attach a copy of the itemized bill from your hospital stating dates you were billed for intensive care confinement and the diagnosis codes for the confinement**.

## Itemized medical bills/statements & corresponding health insurance explanation of benefit statements (EOB's):

Please obtain itemized medical bills from your medical providers. The medical bills need to include the provider name, address and telephone number, date of service, list of all procedures billed, amount billed and corresponding diagnosis code(s). We are unable to process benefits from account summary/balance statements. **Please also include copies of all health insurance explanation of benefit statements which correspond with your itemized medical bills. A copy of your health insurance explanation of benefit statement is needed to process all benefits of the policy which provide for payment of benefits that state "actual charge(s)".**

## Deadline to submit losses/expenses:

All proofs of loss must be received in our office within 15 months from date incurred.

## Submitting Additional Claims:

The Insured does not need to fill out a claim form each time. On a cover sheet or posted note, please write the Insured's name and claim number. Attach it to the first page of the medical bill:
Example: **John Smith - Claim No:**
**Attn: Humana Cancer Claim**

**Questions**
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 cancer and specified disease policy Monday – Friday, 8:00AM-5:00PM, (CST) Central Standard Time.

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

**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)**

| Claim Form for **Cancer, Specified Disease and Intensive Care Coverage**<br>*no claim form required if filing for wellness benefit only* | **Humana Insurance Company**<br>**Administered by: Bay Bridge Administrators, L.L.C.**<br>**PO Box 161690**<br>**Austin TX 78716**<br>**800-845-7519** |
|---|---|

| **INSURED'S STATEMENT OF CLAIM** | | | **TO BE COMPLETED BY POLICYHOLDER** | |
|---|---|---|---|---|
| Name of Insured | | | Policy/Certificate 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 made | | Date of First Diagnosis | | |
| Describe the onset and nature of your illness. | | | | |

| Date you were first treated for your illness<br><br>______________<br>Date | Treated by:<br><br>Hospital: ______________________________________________<br>Name Address<br><br>Doctor: ______________________________________________<br>Name Address |
|---|---|
| Have you ever had the same or a similar condition in the past?<br><br>__ Yes __ No<br><br>______________<br>Date | Treated by:<br><br>Hospital: ______________________________________________<br>Name Address<br><br>Doctor: ______________________________________________<br>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**

# AUTHORIZATION

## FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 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.

_________________________ _________________________ _______________

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 Representative Relationship to Applicant Date

Parent or Guardian *A copy of the legal authority document must be on file with Bay Bridge 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: _______________________ 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 UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.**