

# Humana Insurance Company

## Critical Illness 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.

### **Page 2 – Authorization**

- Claimant or Authorized Representative must sign and date Authorization on page 3 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 on page 3 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:

Bay Bridge Administrators L.L.C.

PO Box 161690

Austin TX 78716

512-275-9350 (fax)

For questions call: 800-845-7519





**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.

Claim Form for **Critical Illness**

**Humana Insurance Company**  
Administered by: Bay Bridge Administrators, L.L.C.  
PO Box 161690  
Austin TX 78716  
800-845-7519

### Physician's Statement

Claimant Name: \_\_\_\_\_ Policy/Certificate #: \_\_\_\_\_

**To Be Completed By the Medical Provider.**

1. Provide the diagnosis(es), the date of diagnosis, and the ICD-9 code(s) for the conditions for which you are treating this patient.

Diagnosis	ICD-9 Code	Date of Diagnosis

2. Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes No

If yes, please provide diagnosis, the dates of treatment and referring physician(s).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

3. Please provide the name and address of any referring physician(s) for this occurrence.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical Provider's Name (Please Print)      Phone Number      Fax Number

\_\_\_\_\_ (    )      (    )

Medical Provider's Signature

Date

\_\_\_\_\_

\_\_\_\_\_

## Physician's Statement – continued

Claimant Name: \_\_\_\_\_ Policy/Certificate #: \_\_\_\_\_

For each condition below for which you are treating this patient, please enclose the information listed under the Medical Documentation Needed section.

If you require prepayment, please contact us at 1-800-845-7519. Otherwise, please bill our office.

Illness (not all illnesses are applicable to all policies.)	Medical Documentation Needed
Heart Attack	Diagnosis based on the following: new EKG changes consistent with and supporting the diagnosis of Heart Attack; elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used); imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
Heart Transplant	Medical records that demonstrate Heart Failure of covered person; and proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human-to-human replacement of the whole heart.
Stroke	Documented neurological impairment or deficits; evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
Coronary Artery Bypass Surgery	Operative report documenting major surgery requiring median sternotomy (division of breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist; results of angiography testing that diagnosed coronary heart disease.
Angioplasty	Coronary Angiography Report along with medical records from the hospital including the discharge summary, which indicates that the procedure was performed.
Invasive Cancer or Malignant Melanoma	Diagnosis based on pathologist's report or, in the event that the cancer was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of cancer.
Carcinoma in Situ	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of carcinoma in situ.
Major Organ Transplant	Medical records that demonstrate Major Organ Failure; and proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ.
End Stage Renal Failure	Documentation of chronic irreversible failure of both kidneys and proof of regular (at least weekly) renal dialysis.

Loss of Vision	Documentation of clinically-proven, irreversible reduction of sight in both eyes as a result of illness or injury. The corrected visual acuity must be less than 20/200 or a visual field restriction to 20 degrees or less in both eyes. There must be clear proof that blindness was due to illness or injury, and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.
Loss of Speech	Documentation of clinically-proven total, permanent and irreversible loss of the ability to speak as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months; documentation regarding general medical opinion whether surgery, a device or implant could result in the partial or total restoration of speech. The diagnosis must be made by physical examination by a speech pathologist.
Loss of Hearing	Documentation of clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis. Documentation regarding general medical opinion, regarding whether surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing. The diagnosis must be made from physical examination by an audiologist.
Coma	Documentation that demonstrates a state of complete and continuous unconsciousness for a period of time, which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes. The diagnosis of Coma must be made by a board-certified Neurologist.
Severe Burns	Medical Records demonstrating that the covered person has sustained third degree burns covering at least a percentage of the surface area of His body. Third degree means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue). The diagnosis of Severe Burns must be made by a physician board-certified in Plastic Surgery
Permanent Paralysis due to Accident	Documentation of Hemiplegia; Paraplegia; or Quadriplegia and that the loss is expected to be permanent; has been present continuously for at least 180 days; is caused by Injury sustained in an Accident occurring after the Effective Date of Insurance; evidenced by the total and irreversible loss of use of two or more limbs; and marked by loss of muscle function in two arms, two legs, or one arm and one leg. Paralysis does not included paralysis that results from a Stroke.
Occupational HIV benefit	Documentation demonstrating all of the following: that the Covered Person initially contracted and was diagnosed with Human Immunodeficiency Virus (HIV) after the Date of Certificate; that the cause of the HIV must be from an accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the twelve (12) months preceding diagnosis; results from blood tests performed within five (5) days of the accident and within twelve (12) months of the accident.
Alzheimer's Dementia	Medical Records demonstrating the loss of intellectual capacity involving impairment of memory and judgment as measured by cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). Documentation should show also demonstrate that this has resulted in significant reduction in mental and social functioning such that the Insured Person requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined in this policy). The diagnosis must be made by a Physician board-certified in Neurology.
Loss of Independent Living Benefit	Medical Records demonstrating the inability to perform two or more Activities of Daily Living without Stand-by Assistance or a Cognitive Impairment.
Diabetes	Medical Records demonstrating the diagnosis for Type 1 or Type 2 Diabetes including the appropriate laboratory tests and physician treatment records, inclusive of all prescribed medications and supplies.
Wellness Benefit	Superbill or HCFA form from the physician indicating the preventative tests performed, including the procedure codes. The claimant's name and policy number should also be indicated on this documentation. No claim form is required.

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