

Humana Insurance Company

Hospital Indemnity 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

*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: _____

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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