HUMANA
Guidance when you need it most

Critical Illness Claim Form Filing Instructions

Page one – Insured's Statement of Claim
- Must be completed each time you file a claim.
- Be sure to answer every question.

Page two – Authorization
- Claimant or Authorized Representative must sign and date Authorization to allow physician to release medical record to Kanawha Insurance Company, a Humana company.

Page three – Pre-existing Investigation Form
- If claim is being filed within the first year of the policy and is for an illness, complete this page with all physicians seen or medications taken in the past 12 months.
- If provider fax numbers are known, provide them in order to expedite this process.
- Make certain authorization on page two is signed and dated.

Page four, five, and six
- Ask your attending physician to complete this section.
- This section must indicate the details of your critical illness and the dates of diagnosis along with any referring physicians.
- Pages five and six provide the physician with the exact medical documentation to attach to their form in order to document the critical illness being claimed.

All portions of this claim form must be completed to avoid delay in the processing of your request for benefits. If you have questions when completing this form, please call 1-877-378-1505.

Mail to the following address:

Kanawha Insurance Company
A Humana company
P.O. Box 2000
Lancaster, SC 29721-2000

Or FAX to:

803-283-5634

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Claim Form for Critical Illness

Insured's Statement of Claim

To be completed by insured

Name of insured ______________________ Policy Number ______________________

Street Address ______________________ City ______________ State _____ ZIP _______

Telephone Number (   ) ______________________ Insured's Date of Birth ______________________

Name of Claimant ____

Relationship to Insured ______________________ Claimant's Date of Birth ______________

Type of critical illness for which claim is being made ______________________________

Date that critical illness was first diagnosed ______________________

Describe the onset and nature of your illness ______________________________

Date you were first treated for your illness or injury ______________________	*Treated by:* Hospital: ______________________________ Name / Address Doctor: ______________________________ Name / Address
Have you ever been treated for the same or a similar condition in the past? ☐ Yes ☐ No	*Treated by:* Hospital: ______________________________ Name / Address Doctor: ______________________________ Name / Address

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements below)

The above statements are true to the best of my knowledge and belief.

______________________________ ______________________________

Signature of Insured Date

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 Kanawha Insurance Company, a Humana company 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 Kanawha Insurance Company, a Humana company, P.O. Box 610, Lancaster, SC 29721. This revocation shall become effective on the date it is received by Kanawha Insurance Company, a Humana company. 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 of Insured	Printed 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 Parent or Guardian	Relationship to Applicant	Date

* A copy of the legal authority document must be on file with Kanawha Insurance Company, a Humana company.

If the claim is being filed during the first 12 months of the policy, complete the following, sign and date the Authorization on the preceding page.

Please list all physicians that treated the patient in the last 12 months:

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 Physician	Date First Prescribed

Claim Form for Critical Illness

Physician's Statement

Claimant Name ______________________ Policy Number ______________________

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).

Diagnosis	ICD-9 Code	Date of Diagnosis

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

Name of Physician	Address

______________________ ( )______________________ ( )______________________
Printed Name of Medical Provider Telephone Number Fax Number

______________________ ______________________
Signature of Medical Provider Date

Kanawha Insurance Company, a Humana Company
P.O. Box 2000
Lancaster, SC 29721-2000
1-800-635-4252

Physician's Statement (Continued)

Claimant Name____ Policy/Certificate Number____________________

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

If you require prepayment, contact us at 1-877-378-1505. Otherwise, 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 echo cardiograms.
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.
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 Disease	Documentation of chronic irreversible failure of both kidneys and proof of regular (at least weekly) renal dialysis.
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 Vision	Documentation of clinically-proven irreversible reduction of sight in both eyes as a result of Accidental Injury or Sickness. The corrected visual acuity must be: less than [20/200]; or visual field restriction to [20] degrees or less in both eyes. The proof must document that the blindness was due to Accidental Injury or Sickness; and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.
Coma	Documentation that demonstrates a state of complete and continuous unconsciousness, 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.
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.

State Specific Fraud Warning Statements

Arkansas
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 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

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the 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.

Kentucky
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.

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.

Maryland
Any person who knowingly and willfully 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.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy 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 an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina
Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio
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.

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.

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.

Kanawha Insurance Company
A Humana company
P.O. Box 2000
Lancaster, SC 29721-2000
Customer Service
1-877-378-1505