



<i>First, Middle, Last</i>		Policy no.		
Policyowner's Name		City		
<i>Street address</i>		<i>State</i>		
Address				
Phone no. ()		Social Security no.		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
			<i>MM/DD/YYYY</i> Policyowner's date of birth	
CLAIM INFORMATION	<i>First, Middle, Last</i> 1. Claimant's name _____			
	<i>MM/DD/YYYY</i> 2. Date of birth _____			
	3. Relationship to Policyowner _____			
	4. Name of medical provider _____		Phone no. () _____	
	Address of medical provider _____			
	<i>MM/DD/YYYY</i> 5. Date of test _____			
	6. Amount charged for screening test \$ _____			
	7. Is itemized billing attached to this form? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Screening test(s) completed:				
<input type="checkbox"/> Mammography screening	<input type="checkbox"/> Hemocult stool specimen	<input type="checkbox"/> Chest X-ray		
<input type="checkbox"/> Pap smear	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Thermography		
<input type="checkbox"/> CA125 (<i>blood test for ovarian cancer</i>)	<input type="checkbox"/> CEA (<i>blood test for colon cancer</i>)	<input type="checkbox"/> Serum protein electrophoresis		
<input type="checkbox"/> PSA (<i>blood test for prostate cancer</i>)	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Other (<i>specify</i>) _____		

IMPORTANT: Prior to submitting this completed form, please read your specific state fraud notice on form 01-004-05055. The Fraud Notice form must be signed and submitted with this form.

I hereby acknowledge that I have read the applicable state fraud notice information on form 01-004-05055.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

_____ _____ _____
Date (MM/DD/YYYY) *Signature of Policyowner or legal representative* *Printed name of person completing this form*



