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** *no claim form required if filing for wellness benefit only*	**Humana Insurance Company** **Administered by: Bay Bridge Administrators, L.L.C.** **PO Box 161690** **Austin TX 78716** **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 _____ Date	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? __ Yes __ No _____ Date	Treated by: Hospital: _____ Name Address Doctor: _____ 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:_____

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.

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.