MEDMUTUAL PROTECT™
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
P.O. Box 9988 Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: ProtectGRPService@MedMutual.com

# ACCIDENT AND HEALTH SCREENING CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within one (1) year from the date of service.
- Please complete Insured/Claimant Statement and mail or fax the completed form to the address or fax number above.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- If an insured person is also covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means that instead of paying the benefits to the insured, we must pay the benefits to Medicaid or the medical provider to reduce the charges billed to Medicaid.

## Insured/Claimant Information

| Insured's Name *(Last, First, Middle)* | Policy/Certificate # | Social Security No. | Date of Birth | Sex |
|---|---|---|---|---|
| | | | | |

| Address *(Street, City, State, Zip)* | |
|---|---|
| | |

| Phone Number *(With Area Code)* | Email Address |
|---|---|
| | |

| Claimant's Name | Date of Birth | Relationship to Insured |
|---|---|---|
| | | |

Please select the accident and health screening undergone by claimant and provide itemized bill indicating patient name, date of service, name of provider and type of service.

Accident Risk Screening Tests *(which includes one or more of the following):*

☐ Epworth Sleepiness Scale

☐ Drug/alcohol abuse assessment/screening

☐ Standard neurological exam (or portions of such exam):

- Mental status testing
- Cranial nerve exam
- Sensorimotor testing
- Cerebellar testing
- Gait/balance assessment
- Pediatric development testing

☐ Hemoglobin A1c

☐ Visual acuity test

☐ Hearing acuity test

☐ Baseline testing for concussions

☐ Bone Density screening

☐ Chest X-ray

☐ EKG

☐ Stress test

☐ Annual physical examination

☐ Other (specify _____)

## AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

| | | | |
|---|---|---|---|
| INSURED'S SIGNATURE: | | DATE: | |
| CLAIMANT'S SIGNATURE: | | DATE: | |