

CANCER AND SPECIFIED DIEESEASE WELLNESS CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within one (1) year from the date of service.
- Please complete Claim Form and mail, fax or email the completed form to the address or fax number indicated above.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please provide all bills associated with your claim, including treatment dates, total charges, diagnoses, and procedure codes and/or itemized bills: HCFA 1500 or UB-92.

Insured/Claimant Information				
Insured's Name <i>(Last, First, Middle)</i>	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Address <i>(Street, City, State, Zip)</i>				
Phone Number <i>(With Area Code)</i>		Email		
Claimant's Name	Date of Birth	Relationship to Insured		

Wellness Screening		
Please check the appropriate wellness screening and provide itemized bill.		
<input type="checkbox"/> Abdominal aortic aneurysm ultrasound	<input type="checkbox"/> CEA (blood test for colon cancer)	<input type="checkbox"/> Hemoccult stool analysis
<input type="checkbox"/> Blood test for triglycerides	<input type="checkbox"/> Chest x-ray	<input type="checkbox"/> Mammography
<input type="checkbox"/> Bone marrow testing	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Pap Smear
<input type="checkbox"/> Bone density screening	<input type="checkbox"/> CT Angiography	<input type="checkbox"/> PSA (blood test for prostate cancer)
<input type="checkbox"/> Breast ultrasound	<input type="checkbox"/> EKG	<input type="checkbox"/> Serum cholesterol HDL/LDL
<input type="checkbox"/> CA 15-3 (blood test for breast cancer)	<input type="checkbox"/> Double contrast barium enema	<input type="checkbox"/> Serum protein electrophoresis (blood test for myeloma)
<input type="checkbox"/> CA 125 (blood test for ovarian cancer)	<input type="checkbox"/> Fasting blood glucose test	<input type="checkbox"/> Stress Test
<input type="checkbox"/> Carotid ultrasound	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Thermography

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:	