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: mailto:ProtectGRPService@MedMutual.com

CANCER/SPECIFIED DISEASE 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.
- If the Claimant traveled more than 60 miles for treatment, please complete the Travel and Lodging Claim Form.
- Please have the treating physician complete the Attending Physician Statement and provide the applicable documents in order to avoid a delay in processing. Your physician may mail, fax or email the completed form to the address or fax number indicated above.

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			
Claimant's Name *(Person who is sick)*	Date of Birth	Relationship to Insured		

Diagnosis Information	
Nature of Cancer/Covered Specified Disease:	Date of Diagnosis:
When did symptoms first appear?	Date of first treatment?
Has claimant ever been treated for or diagnosed as having had the above listed medical condition prior to the effective date of this policy? ☐ Yes ☐ No If yes, when? _____	
Name and address of physician: (list all physicians consulted)	

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:	

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: mailto:ProtectGRPService@MedMutual.com

Cancer and Specified Disease Attending Physician's Statement

Must be completed by physician. Please complete all applicable questions and provide copies of the supporting documentation.

Patient Information

Patient's Full Name	Social Security Number	Date of Birth

Diagnosis? *(ICD 10 code)*	Date of Diagnosis?	When did symptoms first appear?	When did the patient first consult you for this condition?

Cancer

☐ Pathologically diagnosed *(Please attach a copy of the pathology report.)*	☐ Clinically diagnosed *(Please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)*	Has patient ever had the same or similar condition? ☐ Yes ☐ No

Covered Specified Disease

☐ Addison's Disease	☐ Meningitis (epidemic cerebrospinal)	☐ Scarlet Fever
☐ Amyotrophic Lateral Sclerosis	☐ Multiple Sclerosis	☐ Sickle Cell Anemia
☐ Cystic Fibrosis	☐ Muscular Dystrophy	☐ Tay-Sachs Disease
☐ Diphtheria	☐ Myasthenia Gravis	☐ Tetanus
☐ Encephalitis	☐ Niemann-Pick Disease	☐ Toxic Epidermal Necrolysis
☐ Epilepsy	☐ Osteomyelitis, Poliomyelitis	☐ Tuberculosis, Tularemia
☐ Hansen's Disease	☐ Rabies	☐ Typhoid Fever
☐ Legionnaire's Disease	☐ Reye's Syndrome	☐ Undulant Fever
☐ Lupus Erythematosus	☐ Rheumatic Fever	☐ Whipple's Disease
☐ Lyme Disease, Malaria	☐ Rocky Mountain Spotted Fever	

(Please attach copies of medical records documenting diagnosis.)

Heart Attack

Were there new EKG findings consistent with myocardial infarction? ☐ Yes ☐ No	Did the patient show elevation of cardiac enzymes above standard laboratory levels of normal? ☐ Yes ☐ No

(Please attach copies of EKG, lab results, and other diagnostic test results.)

Stroke

Have there been documented neurological deficits persisting for at least 30 days? ☐ Yes ☐ No	Have there been confirmatory neuron-imaging studies? ☐ Yes ☐ No

(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)

Attending Physician Signature

Physician's Name (please print):	Signature:

Tax ID Number:	Phone:	Fax:

Address: Street, City, State, Zip