

Policy Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Patient \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Have you ever had this condition or a similar condition before? If "Yes," please provide complete details.

2. Date on which symptoms were first noticed.

3. Date of first treatment.

4. Names and addresses of physicians or practitioners consulted for this condition.

5. Name of hospitals and date of confinement for this condition.

**Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**AUTHORIZATION**

I hereby authorize any physician, hospital, pharmacy, employer, dentist, coroner/medical examiner, law enforcement agency, insurance organization, consumer reporting agency, or other person or entity possessing any medical information, any information about insurance policies/benefits, or any other information to release all information to Kanawha Insurance Company. This includes any drug, alcohol, psychiatric, HIV infection or AIDS related treatment. A photocopy shall be as valid as the original. The authorization is valid 6 months from the date signed.

\_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_ Address \_\_\_\_\_

If signed on behalf of another, give relationship: \_\_\_\_\_

**SEE REVERSE SIDE FOR ASSIGNMENT OF BENEFITS**

**INSTRUCTIONS FOR FILING A CLAIM**

**HOSPITAL CONFINEMENT:** Submit itemized inpatient hospital bill attached to a claim form.

**SURGEON/PHYSICAL:** Complete Attending Physician's Statement or similar form using Current Procedural Terminology (CPT-4) Codes for all surgical procedures. All statements and reports should be attached to a claim form.

**OTHER COVERED EXPENSES:** Furnish itemized details of service rendered and charge for each service or visit. All items should be attached to a claim form.

Positive proof of cancer must be furnished to establish a claim. Generally, proof is a pathologist's report or, in the event the cancer was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of cancer. All reports should be attached to a claim form.

Mail completed claims and other documentation (attached to claim forms) to:

KANAWHA INSURANCE COMPANY  
ATTENTION: BENEFITS DEPARTMENT  
POST OFFICE BOX 2000  
LANCASTER SC 29721-2000

ATTENDING PHYSICIAN'S REPORT

**HEALTH INSURANCE CLAIM — INDIVIDUAL CANCER**

**PART A TO BE COMPLETED BY PATIENT (INSURED)**

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
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INSURED'S NAME IF PATIENT IS A DEPENDENT \_\_\_\_\_

NAME OF INSURANCE COMPANY <b>Kanawha Insurance Company</b>	POLICY NUMBER	INSURED'S SOCIAL SECURITY NUMBER
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AUTHORIZATION TO PAY BENEFITS TO HOSPITAL AND PHYSICIANS: I further authorize payment directly to the hospital and Physician(s) accepting this assignment of all hospitalization and medical benefits applicable and otherwise payable to me, but not to exceed the REASONABLE AND CUSTOMARY CHARGE for these services rendered by said hospital and Physician(s) as indicated in the following Physician's Report and any attached statements of charges for medical services.

SIGNATURE OF INSURED PERSON \_\_\_\_\_ DATE \_\_\_\_\_

**PART B ATTENDING PHYSICIAN'S STATEMENT**

1. DIAGNOSIS AND CONCURRENT CONDITIONS (if diagnosis code other than ICDA\* used, give name): \_\_\_\_\_

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?  Yes  No PREGNANCY? If "Yes," enter approximate date  Yes  No pregnancy commenced.

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (if previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CPT-4 PROCEDURE CODE	CHARGES

If Laceration—Show Size or No. of Sutures \_\_\_\_\_

If Skin Graft—Show Area and Type of Graft \_\_\_\_\_

TOTAL CHARGES→ \$ \_\_\_\_\_  
 AMOUNT PAID→ \$ \_\_\_\_\_  
 BALANCE DUE→ \$ \_\_\_\_\_

†O—Doctor's Office    IH—Inpatient Hospital    NH—Nursing Home  
 H—Patient's Home    OH—Outpatient Hospital    OL—Other Locations  
 \*ICDA—International Classification of Diseases

4. DATE SYMPTOMS FIRST APPEARED \_\_\_\_\_ 5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: \_\_\_\_\_

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?  Yes  No If "Yes," when and describe: \_\_\_\_\_ 7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?  Yes  No

8. Has patient been treated by another physician?  Yes  No If so, by whom? \_\_\_\_\_

9. Was patient referred to you?  Yes  No If so, by whom? \_\_\_\_\_

10. Was this an injury?  Yes  No Give details \_\_\_\_\_

11. I DO NOT ACCEPT ASSIGNMENT.

DATE \_\_\_\_\_ PHYSICIAN'S NAME (PRINT) \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DEGREE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY OR TOWN \_\_\_\_\_ STATE OR PROVINCE \_\_\_\_\_ ZIP CODE \_\_\_\_\_