MEDICARE SUPPLEMENT BENEFIT REQUEST FORM

KANAWHA INSURANCE COMPANY

MAIL COMPLETED FORM TO: **KANAWHA INSURANCE COMPANY**
POST OFFICE BOX 2000
LANCASTER, SOUTH CAROLINA 29721-2000

1

TO BE COMPLETED BY THE INSURED

YOUR APPLICATION FOR BENEFITS MAY BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED.

(Last First Middle)	Patient's Birthdate Mo. Day Yr.	Relationship To Insured	Patient's Sex
Patient's Name		☐ Self ☐ Spouse	☐ M ☐ F

(Street City State Zip Code)	Is this a New Address?
Home Address	☐ Yes ☐ No

Policy Number	Insured's Social Security Number	Telephone Number
Was Condition Related to Patient's Employment ☐ Yes ☐ No	Was Condition Related to an Accident ☐ Yes ☐ No	If an Accident Date _____ 20 _____ and time _____ ☐ AM ☐ PM

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 _____

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.

2

COMPLETE ONLY IF BENEFITS ARE TO BE PAID TO YOUR PHYSICIAN OR SUPPLIER

Physician's or Supplier's Name

Street

City State Zip Code

I authorize payment of medical benefits to the Physician or Supplier for the service described herein or attached.

_____
Signature (Authorized Person)

_____
Date

INSTRUCTIONS FOR FILING A CLAIM

HOSPITAL, DOCTOR AND OTHER MEDICAL CLAIMS

Step 1 Complete SECTION 1 above. Be sure to answer every item. Sign and date the authorization for your doctor to release information to KANAWHA.

Step 2 If you want benefits paid directly to you, do not complete SECTION 2 above.
If you want benefits paid to your doctor or hospital, complete and sign SECTION 2 above.

Step 3 If your claim was incurred during the first 6 months after you bought your policy, have your doctor complete SECTION 3 on the back of this form. Otherwise, it is not necessary to complete SECTION 3.

Step 4 Wait until Medicare sends you an "Explanation of Medicare Benefits" form. ATTACH THE MEDICARE FORM (and any other claim material) TO THIS FORM and mail your claim to KANAWHA.
PLEASE NOTE: We cannot pay your full benefits from your policy until we know how much Medicare has paid.

PRESCRIPTION DRUG EXPENSES

Step 1 If you have purchased this extra coverage, complete SECTION 1 above. Be sure to answer every item.

Step 2 Have your pharmacist complete SECTION 4 on the back of this form. Mail your claim to KANAWHA.

3

TO BE COMPLETED BY THE PHYSICIAN OR SUPPLIER

(REQUIRED ONLY IF CLAIM INCURRED WITHIN A PERIOD OF 3 MONTHS FROM THE POLICY DATE)

DATE OF ILLNESS (First Symptom) OR INJURY (Accident)	Date First Consulted You for this Condition	Has Patient Ever Had Same or Similar Symptom? ☐ Yes ☐ No	If an Emergency Check Here ☐

Patient Still under Your Care ☐ Yes ☐ No	Name of Referring Physician	For Services Related to Hospitalization, Give Dates Admitted / Discharged

Name and Address of Facility Where Services Rendered (If other than home or office)	Was Laboratory Work Performed Outside Office? ☐ Yes ☐ No Charges

ICD-9 Code or Narrative Description

1.

2.

3.

Date Of Service	Place Of Service	CPT Procedure Code	Fully Describe Procedures, Medical Services Or Supplies Furnished For Each Date Given (Explain Unusual Services or Circumstances).	Days Or Units	Charges

SIGNATURE OF PHYSICIAN OR SUPPLIER	ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
Signed _____ Date _____				

PATIENT'S ACCOUNT NUMBER	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER Is this a New Address? ☐ Yes ☐ No