

## Cancer Claim Filing Instructions

### Instructions for completing the claim form:

#### Page 1

- Complete policy and insured information and answer all questions.

#### Page 2 – Authorization

- Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to KHS.

#### Page 3 – Pre-existing Investigation Form

- If claim is being filed within the first 2 years of the policy and is for an illness, please complete this page with all physicians seen or medications taken in the past 12 months.
- If provider fax numbers are known, please provide them in order to expedite this process.
- Please make certain authorization on page 2 is signed and dated.

#### Page 4 Attending Physician's Report

- Ask your attending physician to complete this section.
- This section must indicate the details of your critical illness and dates of diagnosis along with any referring physicians.

**A Copy of the pathology report showing a definitive diagnosis of cancer should be submitted with the completed claim form.**

ALL PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS. IF YOU HAVE ANY QUESTIONS WHEN COMPLETING THIS FORM, PLEASE CALL 1-877-378-1505.

### Please MAIL to the following address:

Kanawha Insurance Company  
P.O. Box 2000  
Lancaster, SC 29721

### Or, you may FAX to the following number:

(803) 283-5634

**Cancer Claim Form**

**Statement of Claim (To be completed by employee)**

Name \_\_\_\_\_ Policy/Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Name of Claimant \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Claimant's Date of Birth \_\_\_\_\_

Type of Cancer for which claim is being made \_\_\_\_\_

Date Cancer was first diagnosed \_\_\_\_\_

Describe the onset and nature of your illness \_\_\_\_\_

Date you were first treated for your illness or injury \_\_\_\_\_

Name of Hospital where you were treated \_\_\_\_\_ Address \_\_\_\_\_

Name of Physician who treated you \_\_\_\_\_ Address \_\_\_\_\_

Have you ever been treated for the same or a similar condition in the past?  Yes  No

If Yes, name of hospital where treated \_\_\_\_\_ Address \_\_\_\_\_

Name of Physician who treated you \_\_\_\_\_ Address \_\_\_\_\_

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

*The above statements are true to the best of my knowledge and belief.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Authorization**  
**For the Use and Disclosure of Protected Health Information**

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information.
3. I authorize only designated staff of Kanawha HealthCare Solutions, Inc., Kanawha Insurance Company and its successors and assignees to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be redisclosed and would no longer be protected.
5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Kanawha HealthCare Solutions, Inc., P.O. Box 610, Lancaster, SC 29721-0610. This Evocation shall become effective on the date it is received by Kanawha HealthCare Solutions, Inc., Kanawha Insurance Company and its successors and assignees I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twelve (12) months from the date of execution hereof.

***I certify that I have received a copy of this Authorization and authorize the use and /or disclosure of my protected health information as contemplated herein.***

---

Signature	Printed Name	Date
-----------	--------------	------

***I have legal authority\* under the laws of the State of \_\_\_\_\_ to make health care decisions on behalf of \_\_\_\_\_, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.***

---

Name of Authorized Representative Parent or Guardian	Relationship to Applicant	Date
---	---------------------------	------

\* A copy of the legal authority document must be on file with Kanawha HealthCare Solutions, Inc.

***If the claim is being filed during the first year of the policy, complete the following, sign and date the Authorization on the preceding page.***

---

**List all physicians that treated the patient in the last year.**

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Approximate Date Consulted \_\_\_\_\_ Diagnosis \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Approximate Date Consulted \_\_\_\_\_ Diagnosis \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Approximate Date Consulted \_\_\_\_\_ Diagnosis \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Approximate Date Consulted \_\_\_\_\_ Diagnosis \_\_\_\_\_

**List all prescribed medications now being taken by the patient.**

Name Of Medication	Prescribing Physician	Date First Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is subject to prosecution and punishment for insurance fraud.***

**Cancer Claim Form**

**Physician's Statement**

Claimant Name \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_

**To Be Completed By the Medical Provider.**

1. Provide the diagnosis(es), the date of diagnosis, and the ICD-9 code(s) for the conditions for which you are treating this patient.

Diagnosis	ICD-9 Code	Date of Diagnosis

2. Please provide the date the symptoms first appeared. \_\_\_\_\_  
Please provide the date the patient first consulted you for this condition. \_\_\_\_\_

3. Has this patient been treated for this same or similar condition in the past prior to this occurrence?  Yes  No  
If yes, please provide diagnosis, the dates of treatment and referring physician(s).  
\_\_\_\_\_  
\_\_\_\_\_

4. Please provide the name and address of any referring physician(s) for this occurrence.  
\_\_\_\_\_  
\_\_\_\_\_

5. Please attach a copy of the pathology report establishing the diagnosis of cancer. If cancer is established by a clinical or non-pathological diagnosis, please provide a brief statement, records and other information providing a basis for the diagnosis of cancer.  
\_\_\_\_\_  
\_\_\_\_\_

Medical Provider's Name (Please Print) \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
\_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Signature of Medical Provider \_\_\_\_\_ Date \_\_\_\_\_