MEDICAL ILLNESS CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

PLEASE READ BEFORE COMPLETING THIS FORM

The furnishing of this form is for the convenience of the policyholder and is not an acknowledgement of liability or waiver of any right.

INSTRUCTIONS:

1. Complete Policyholder/Patient Information on this page.
2. Be sure to sign your claim form at the bottom of this page.
3. **If you are filing for disability**, please complete the "Individual Disability Notice of Claim" form.

ADDITIONAL NOTES:

1. Submit all bills related to this claim such as doctor, hospital (must include the number of days confined, if applicable), ambulance, follow-up visits, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered, date of service and actual charges for the service.
2. Be sure to include your policy number on all documents.
3. Provide list of physicians seen in last 2 years.
4. Complete HIPAA form

POLICYHOLDER'S INFORMATION

Policyholder Name (Last, first, middle initial)		Policy Number
Address (City, State, Zip Code)	❑Check This Box If This A New Permanent Address	
Social Security Number	Date of Birth	Telephone Number

PATIENT'S INFORMATION

Patient Name (Last, First, Middle Initial)		Social Security Number	Date of Birth	Height and Weight
❑ Male ❑ Female	❑Single ❑ Other ❑Married	Relationship:	❑ Self ❑ Dependent ❑ Spouse ❑ Check if dependent is full-time student	
*If the patient (child) is over age 19 and a full-time student, provide the name of the school being attended:		School's Address _____		

***If you have not previously submitted proof of full-time student status for the period of the medical expenses submitted, you must do so before the claim can be processed.**

What illness was suffered?		On what date did you first notice you were beginning to get sick? (MM/DD/YYYY) ❑ AM ❑ PM	
Have you ever had the same illness before? ❑ Yes ❑ No	If YES, when? (MM/DD/YYYY)	Date you were first treated by a physician for the illness? (MM/DD/YYYY)	
Were you hospitalized? ** ❑ Yes ❑ No	If YES, on what date were you admitted? (MM/DD/YYYY)	On what date were you released? (MM/DD/YYYY)	
Have you had any medical or surgical advice during the past 5 years for any other condition? ❑Yes ❑ No	If YES, for what?	When? (MM/DD/YYYY)	
Physician's Name and Address			
Has any other physician treated you for this illness? ❑ Yes ❑ No	When? (MM/DD/YYYY)		
Physician's Name and Address			

**If you were in the hospital, please attach an itemized statement.

I authorize any hospital, physician, or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment relative to my person, and to furnish copies of all hospital or medical records. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. I understand and agree and if payment of benefits to me results in an overpayment, the Company may deduct the amount of the overpayment from future benefit payments.

_____ _____

Signature (If Claim Is For A Minor, Parent Or Legal Guardian Must Sign) Date

Submit Completed Form to:
Claims Department
P.O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
manhattanlife.com

MEDILL 0317

ManhattanLife™

Authorization for the Release of Protected Health Information

Patient Name: _____

Social Security Number: _____

Date of Birth: _____

Policy Number: _____

I, _____, hereby authorize _____'s designated medical custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the person(s) or organization(s):

Name of Person(s) or Organization(s):

(Company Name)
10777 Northwest Fwy
P.O. Box 925309
Houston TX 77292-5309

I specifically authorize the use and disclosure of the following PHI:

_____
_____
_____
_____

(Specifically describe the protected health information to be disclosed. Include meaningful descriptors such as date of service, type of service provided, level of detail to be released, etc.)

This protected health information is being used or disclosed to carry out treatment, payment, and/or the _____'s internal operations in the following manner:

_____
_____
_____
_____

(Specifically describe how protected health information will be used to carry out treatment, payment, or the company's internal operations purposes.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand and agree that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the use or disclosure of the PHI (protected health information).
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The company will not condition my treatment, payment, and enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- I have the right to refuse to sign this authorization form.

_____
Signature

_____
Date

_____

_____
Description of Personal Representative's Authority

ManhattanLife™