MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
P.O. Box 14327 Reading, PA 19612
Telephone: 855.521.9345 Fax: 610.374.6986
Portal: https://medmutualprotect.loomislive.com

# ACCIDENT 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 Physician's documentation of your accidental injury.
- 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 50 miles for treatment, please complete the Travel and Lodging Claim Form.
- If the accident resulted in death, please complete the Death Benefit Claim Form.
- If an insured person is also covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means that instead of paying the benefits to the insured, we must pay the benefits to Medicaid or the medial provider to reduce the charges billed to Medicaid.
- Review the Important Claims Information on the back of this form.

## Insured/Claimant Information

| Insured's Name *(Last, First, Middle)* | Policy/Certificate # | Social Security No. | Date of Birth | Sex |
|---|---|---|---|---|
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| Address *(Street, City, State, Zip)* |
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| Phone Number *(With Area Code)* | Email |
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| Claimant's Name *(Person who is sick)* | Date of Birth | Relationship to Insured |
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## Accidental Injury Information

| Date of Accident: | Date of Initial Treatment: | If auto accident: ☐ Driver ☐ Passenger ☐ Unknown<br>(Please provide a copy of the police report and any other incidents investigated by any law enforcement agency) |
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| Describe how and where it happened: |
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| Is your accident related to your occupation?<br>☐ Yes ☐ No | Is your accident covered by Worker's Compensation?<br>☐ Yes ☐ No |
|---|---|

## 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.

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|---|---|---|---|
| INSURED'S SIGNATURE: | | DATE: | |
| CLAIMANT'S SIGNATURE: | | DATE: | |