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

CANCER AND SPECIFIED DISEASE 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 all bills associated with your claim, including treatment dates, total charges, diagnoses and procedure codes and/or itemized bills: HCFA 1500 or UB-92.
- Please have the treating physician complete the Attending Physician Statement and provide the applicable documents in order to avoid a delay in processing. Your physician may mail, fax or email the completed form to the address or fax number indicated above.
- Review the Important Claims Information at the end of this form.

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

Critical Illness Diagnosis Information	
Nature of Cancer/Covered Specified Disease:	Date of Diagnosis:
When did symptoms first appear?	Date of first treatment?
Has claimant ever been treated for or diagnosed as having had the above listed medical condition prior to the effective date of this policy? ☐ Yes ☐ No If yes, when? _____	
Name and address of physician: (list all physicians consulted)	

Non-Local Transportation and Lodging		
Did claimant travel more than 60 miles one way for outpatient treatment for this condition? ☐ Yes ☐ No		Name and address of physician/facility:
Outpatient Treatment Dates: _____		
☐ Transportation: ☐ Auto ☐ Plane *(Attach copy of ticket)*	☐ Lodging: *(Provide lodging receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)*	

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Adult Companion Transportation and Lodging		
Was claimant confined to a hospital for this condition, more than 60 miles one way from the claimant's legal address? ☐ Yes ☐ No		Please provide name and address of hospital:
Admission Date: _____	Discharge Date: _____	
☐ Transportation: ☐ Auto ☐ Plane *(Attach copy of ticket)*		☐ Lodging: *(Attach receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)*

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.

INSURED'S SIGNATURE:		DATE:	
CLAIMANT'S SIGNATURE:		DATE:	

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Cancer and Specified Disease Attending Physician's Statement

Must be completed by physician. Please complete all applicable questions and provide copies of the supporting documentation.

Patient Information

Patient's Full Name	Social Security Number	Date of Birth

Diagnosis: *(ICD 10 code)*	Date of Diagnosis:	When did symptoms first appear?	When did the patient first consult you for this condition?

Cancer

☐ Pathologically diagnosed (Please attach a copy of the pathology report.)	☐ Clinically diagnosed (Please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)	Has patient ever had the same or similar condition? ☐ Yes ☐ No

Specified Disease

☐ Addison's Disease	☐ Meningitis (epidemic cerebrospinal)	☐ Scarlet Fever
☐ Amyotrophic Lateral Sclerosis	☐ Multiple Sclerosis	☐ Sickle Cell Anemia
☐ Cystic Fibrosis	☐ Muscular Dystrophy	☐ Tay-Sachs Disease
☐ Diphtheria	☐ Myasthenia Gravis	☐ Tetanus
☐ Encephalitis	☐ Niemann-Pick Disease	☐ Toxic Epidermal Necrolysis
☐ Epilepsy	☐ Osteomyelitis, Poliomyelitis	☐ Tuberculosis, Tularemia
☐ Hansen's Disease	☐ Rabies	☐ Typhoid Fever
☐ Legionnaire's Disease	☐ Reye's Syndrome	☐ Undulant Fever
☐ Lupus Erythematosus	☐ Rheumatic Fever	☐ Whipple's Disease
☐ Lyme Disease, Malaria	☐ Rocky Mountain Spotted Fever	

(Please attach copies of medical records documenting diagnosis.)

Attending Physician Signature

Physician's Name (please print):	Signature:

Tax ID Number:	Phone:	Fax:

Address: Street, City, State, Zip