

Humana Insurance Company

Accident, Sickness, Heart Attack/Heart Disease/Stroke Claim Filing Instructions

Page 1 – Insured’s Statement of Claim:

Must be completed each time you file a claim. Be sure to answer every question. If filing a claim due to accident/injury where a police report was filed, a copy of the police report must be included with claim.

Page 2 – Authorization

Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to Bay Bridge Administrators, LLC

Pages 3 & 4 – Pre-existing Review Form

If claim is being filed within the first two years of the policy, please complete this page with all physicians seen or medications taken in the past 24 months.

If provider fax numbers are known, please provide them in order to expedite this process. Please make certain authorization is signed and dated.

Pages 5 - Employer’s Statement

If you are filing for total disability benefits under the accident policy, this form must be completed by your Employer representative.

Pages 6 & 7 - Physician’s Statement

To be completed by your treating Physician. If treated in an emergency room, the admit and discharge summary may be submitted in lieu of this form.

Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation by mail or fax to: Humana
Claims

Bay Bridge Administrators, LLC

PO Box 161690

Austin TX 78716

512-275-9350 (fax)

For questions call: 800-845-7519

Claim Form for Accident, Heart Attack/Heart Disease & Stroke	Humana Insurance Company Administered by: Bay Bridge Administrators, LLC PO Box 161690 Austin TX 78716 800-845-7519
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INSURED’S STATEMENT OF CLAIM
TO BE COMPLETED BY POLICYHOLDER

Name of Insured			
Street Address		Policy Number	
Phone Number (Area Code First)	City	State	Zip Code
Name of Claimant		Insured’s Date of Birth	
Illness or Injury for which claim is being made	Relationship to Insured	Claimant’s Date of Birth	
Describe the onset and nature of your illness or injury		Date of Accident or Date Illness was First Diagnosed	

Date you were first treated for your illness or injury:	
Date	
Have you ever had the same or a similar condition in the past? ___Yes ___No Date _____	Treated by:
	Hospital: _____ Name Address
	Doctor: _____ Name Address
	Treated by:
	Hospital: _____ Address
	Doctor: _____ Name Address

Only complete the following portion if covered by and applying for Disability benefits under the optional rider on the Accident Policy

6. Between what dates were you totally and continuously disabled? From _____, 20____to _____, 20____

7. Between what dates were you partially disabled? From _____, 20____to _____, 20____

8. If still disabled, when do expect to resume full duties? _____

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.

Signature of Insured _____

Date _____

The above Statements are true to the best of my knowledge and belief

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 Bay Bridge Administrators, LLC. 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 re-disclosed 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 Bay Bridge Administrators, LLC. This revocation shall become effective on the date it is received by Bay Bridge Administrators, LLC. 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	_____ Print Name	_____ Date
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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	_____ Relationship to Applicant	_____ Date
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Parent or Guardian* A copy of the legal authority document must be on file with Bay Bridge Administrators, LLC

If claim is being filed during the first two years of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last 5 years:

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: _____

Physician's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

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.

Return fully completed claim form and supporting documentation by mail or fax to:

Bay Bridge Administrators, LLC

PO Box 161690

Austin TX 78716

512-275-9350 (fax)

For questions call: 800-845-7519

Employer's Statement**Humana Insurance Company**

To be completed by Employer		
Employee's Name:	SSN:	Date of Birth:
Date last worked: _____	Has Employee returned to work? Yes ☐ No ☐	
Reason for stopping work: _____	If yes, full-time date: _____	
_____	Part-time date: _____	
Is employee's job being held open?		
Name and Address of Employer:		
Employer Signature	Date Signed	
Printed Name and Title	Employer's Telephone Number	
E-mail address	Fax Number	

Return fully completed form by mail or fax to: Humana Claims
Bay Bridge Administrators, L.L.C.
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

Physician's Statement

To be completed by the Medical Provider		
Claimant Name	Date of Birth	
Diagnosis	ICD-9 Code	Date of Diagnosis
Date Disability Commenced ___/___/___		
Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐	Dates of Treatment Date of first visit ___/___/___ Date of last visit ___/___/___	Frequency of treatment Weekly ☐ Monthly ☐ Other
Has patient been hospital confined for this condition? Yes ☐ No ☐ If yes, please list name of hospital and dates:		
Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes ☐ No ☐		
If yes, Diagnosis:	Dates of Treatment	Name and address of Referring Physician:
Nature of Treatment – please describe course of treatment:		
Progress: (a) prognosis with reasonable estimate of return to work date		
Medical Provider's Name (Please Print)	Phone Number	Fax Number
Limitations (what the patient CANNOT do)		

Physical Impairment *as defined in Federal Dictionary of Occupational Titles)	☐ Class I – No limitation of functional capacity; capable of heavy work *no restrictions (0-10%) ☐ Class 2 – Medium manual activity *(15-30%) ☐ Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%) ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%) ☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)	
Remarks:		
Medical Provider's Signature	Date Signed	
Name of Physician (Please Print)	Telephone Number	Fax Number
Mailing Address		

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State Specific Fraud Warning Statements

Arkansas

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.

California

For your protection, California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

District of Columbia

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Louisiana

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.

Maryland

Any person who knowingly and willfully 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.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico

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 civil fines and criminal penalties.

North Carolina

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island

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.

Tennessee, Virginia and Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.