

Hospital Indemnity Claim Form Filing Instructions

Page one – Insured’s Statement of Claim

- Must be completed each time you file a claim.
- Be sure to answer every question.

Page two – Authorization

- Claimant or Authorized Representative must sign and date Authorization to allow physician to release medical records to Kanawha Insurance Company, a Humana company.

Page three – Pre-existing Investigation Form

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

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

All required portions of this claim form must be completed to avoid delay in the processing of your request for benefits. If you have questions when completing this form, please call 1-877-378-1505.

Mail to the following address:

Kanawha Insurance Company

A Humana company
P.O. Box 2000
Lancaster, SC 29721-2000

Or FAX to:

(803) 283-5545

Claim Form for Hospital Indemnity

Insured's Statement of Claim

To be completed by insured

Name of insured _____ 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 _____

Illness or Injury for which claim is being made _____

Date of Accident or Date Illness was First Diagnosed _____

Describe the onset and nature of your illness or the date and details of your accident. _____

Date you were first treated
for your illness or injury

Treated by:

Hospital: _____
Name Address

Doctor: _____
Name Address

Have you ever had the
same or a similar condition
in the past?

Yes No

Treated by:

Hospital: _____
Name Address

Doctor: _____
Name Address

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements below)

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

Signature of Insured

Date

Kanawha Insurance Company, a Humana Company
P.O. Box 2000
Lancaster, SC 29721-2000
1-800-635-4252

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 Insurance Company, a Humana company 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 Kanawha Insurance Company, a Humana company, P.O. Box 610, Lancaster, SC 29721. This revocation shall become effective on the date it is received by Kanawha Insurance Company, a Humana company. 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 of Insured	Printed 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 Parent or Guardian	Relationship to Applicant	Date
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* A copy of the legal authority document must be on file with Kanawha Insurance Company, a Humana company.

If the claim is being filed during the first 12 months of the policy, complete the following, sign and date the Authorization on the preceding page.

Please list all physicians that treated the patient in the last 12 months:

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 Physician	Date First Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

Kanawha Insurance Company
A Humana company
P.O. Box 2000
Lancaster, SC 29721-2000
Customer Service
1-877-378-1505