



Underwritten by  
United of Omaha Life Insurance Company  
Mutual of Omaha Insurance Company  
Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza  
Omaha, NE 68175-0001  
Toll Free (800) 775-8805  
Fax (402) 997-1835  
Email [submitgrpci@mutualofomaha.com](mailto:submitgrpci@mutualofomaha.com)

## **A Guide for Successfully Completing the Group Critical Illness/Specified Disease Claim Form**

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group critical illness/specified disease benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

### **Important Tips for Paper Copy Submission**

Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed. All parts of this form are to be completed without expense to the underwriting company.

- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.
- Please use the Group Health Benefit Screening Claim Form for all health screening benefit claims.
- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.

### **Required Fraud Warnings**

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

### **Guidelines for Section 1: Employee/Member, Patient & Claimant Statement**

This section is to be completed by the Employee/Member. Dates should include month, date and year. In order to be considered complete, the form must be signed by you.

### **Guidelines for Section 2: Physician, Hospital and Medication Information**

This section is required if this claim is being filed within the first year following the effective date of insurance for the Patient.

### **Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer**

Both authorizations are to be completed by the Employee. Dates should include the month, date and year.

### **Guidelines for Section 3: Policyholder/Employer Statement**

This section is to be completed by the policyholder/employer. In order to be considered complete, the form must be signed by the policyholder/employer.

### **Guidelines for Section 4: Attending Physician Statement**

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

# Fraud Warnings

## Required Fraud Warnings (State specific warnings apply to the resident of such state)

**Fraud Warning:** 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.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee:** Any person who, with 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 is guilty of insurance fraud.

**California:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

**Kansas:** 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 as determined by a court of law.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oregon:** 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 may be a crime and may subject such person to criminal and civil penalties.

**Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virgin Islands:** 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 penalties.

**Virginia:** Any person who, with the 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 may have violated state law.

# Group Critical Illness/Specified Disease Claim Form

## Employer Information

Policyholder/Employer Name		Group ID Number G000 ____
City	State	ZIP Code

## Employee/Claimant Information

Employee Name (First, MI, Last)		Employee Date of Birth (MM/DD/YYYY)	Employee SSN
Employee Street Address	Employee City	Employee State	Employee ZIP Code
Employee Email Address	Employee Phone Number	Preferred method of Contact (Emailed/Phone Call) <input type="button" value="v"/>	
Employee Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Smoker or Non-Smoker <input type="button" value="v"/>	Employee Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	

## Patient/Claimant Information - Only complete this section if the Patient is not the Employee

Patient Name (First, MI, Last)			
Patient Street Address	Patient City	Patient State	Patient ZIP Code
Patient Date of Birth (MM/DD/YYYY)	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient SSN or ID Number	Patient Relationship to Employee/Member
If the Patient is the Child of the Employee/Member, if over age 18, is the Child a Full-Time Student? <input type="checkbox"/> Yes† <input type="checkbox"/> No	If the Patient is the Child of the Employee/Member, is the Child married or in a partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Eligibility Information (Only applicable for CA, DC, MA, NJ and NY)

Does the Employee/Member and the Patient (if not the Employee/Member) have Major Medical Insurance, or a combination of Basic Hospital and Basic Medical Insurance? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If Yes, provide name of insurance carrier and policy number for the Employee/Member and the Patient (if different):
---	--

Please check the Illness/Procedure for which this Claim is being filed. The Illness/Procedure selected must be included in your Certificate for the Claim to be considered. Refer to the Definitions in your Certificate for additional information, if needed.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Attack (Myocardial Infarction)    | <input type="checkbox"/> Major Organ Transplant/Placement on UNOS List | <input type="checkbox"/> Cerebral Palsy (children only)                   |
| <input type="checkbox"/> Heart Transplant/Placement on UNOS List | <input type="checkbox"/> End-Stage Renal Failure                       | <input type="checkbox"/> Structural Congenital Defect(s) (children only)  |
| <input type="checkbox"/> Heart Valve Surgery                     | <input type="checkbox"/> Acute Respiratory Distress Syndrome (ARDS)    | <input type="checkbox"/> Genetic Disorder(s) (children only)              |
| <input type="checkbox"/> Coronary Artery Bypass                  | <input type="checkbox"/> Cancer (Invasive)                             | <input type="checkbox"/> Congenital Metabolic Disorder(s) (children only) |
| <input type="checkbox"/> Aortic Surgery                          | <input type="checkbox"/> Bone Marrow Transplant                        | <input type="checkbox"/> Type 1 Diabetes (children only)                  |
| <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Carcinoma in Situ                             | <input type="checkbox"/> ALS (Lou Gehrig's) Disease                       |
|  | <input type="checkbox"/> Benign Brain Tumor                            | <input type="checkbox"/> Advanced Alzheimer's Disease                     |
|  | <input type="checkbox"/> Skin Cancer                                   | <input type="checkbox"/> Advanced Parkinson's Disease                     |

Date the Patient was diagnosed with the illness or need for the procedure, or the date the procedure was performed (MM/DD/YYYY):

Briefly describe the illness or procedure:

Has the Patient ever had the same or similar illness/procedure? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If Yes, provide the date of prior illness/procedure and date of last treatment (MM/DD/YYYY):
---	---

Has a benefit ever been paid for the Patient under any other Critical Illness/Specified Disease Policy sponsored by the Policyholder/Employer? <input type="checkbox"/> Yes† <input type="checkbox"/> No	†If Yes, provide the date (MM/DD/YYYY) and amount of each benefit:
--	--

**If the Patient was hospitalized for the Illness/Procedure stated above, provide hospital information:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason for Visit/Care	

**Provide information for any other hospital at which the Patient received care for the Illness/Procedure:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason for Visit/Care	

**Provide information for the Patient's Primary Care Physician (Ex. Family Doctor or Pediatrician):**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code

**Provide information for the Patient's Attending or Treating Physician/Specialist for the Illness/Procedure stated in Section 4:**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code

\*\*If the Patient was treated at more than two hospitals or by more than two physicians, provide the information required above for each hospital or physician on a separate sheet of paper and submit it with this claim.\*\*

Who is the Claimant (the person filing this claim)?  Employee/Member  Spouse/Partner  Beneficiary  Other\*\* (Ex. Power of Attorney, Conservator)

**COMPLETE THE FOLLOWING ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER**

Claimant Last Name	Claimant First Name	Claimant MI	Claimant Email Address
Claimant Street Address	Claimant City	Claimant State	Claimant ZIP Code
Claimant Date of Birth (MM/DD/YYYY)	Claimant SSN or ID Number	Claimant Home Phone Number	Claimant Cell Phone Number
If applicable, relationship to Employee/Member	If applicable, type of Legal Representative		

**\*\*If other, such as power of attorney or conservator, a copy of the document granting authority must be submitted with this claim.\*\***

## Physician, Hospital and Medication Information

Employee/Member Name	Employee/Member SSN or ID Number	Group ID Number G000 ____
Patient Name (If not the Employee/Member)	Patient SSN or ID Number (If not the Employee/Member)	

Patient Date of Birth (MM/DD/YYYY)	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)
------------------------------------	---	--

**If the Patient was hospitalized within the year prior to the effective date of insurance for the Patient, provide the following:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason for Visit/Care	

**Provide information for any other hospital at which the Patient was hospitalized within the year prior to the effective date of insurance for the Patient:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason For Visit/Care	

\*\*If the Patient was treated at more than two hospitals, provide the information required above for each additional hospital on a separate sheet of paper and submit it with this form.\*\*

**If the Patient was treated by any physician within the year prior to the effective date of insurance for the Patient, provide physician information:**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code

**Provide information for any other physician from whom the Patient received treatment within the year prior to the effective date of insurance for the Patient:**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code

\*\*If the Patient was treated by more than two physicians, provide the information required above for each additional physician on a separate sheet of paper and submit it with this form.\*\*

**List any over-the-counter drugs, prescription drugs or medication taken by the Patient for any reason within the year prior to the effective date of insurance for the Patient:**

Name of Drug/Medicine	Date(s) Taken	Pharmacy Name, Phone, City & State	Prescribing Physician Name

\*\*If there are additional drugs/medicines to be listed, provide the information required above for each additional drug/medicine on a separate sheet of paper and submit it with this form.\*\*

**By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.**

Signature of Claimant	Date
Signature of Patient, if age 18 or older (and not the Claimant) <input type="checkbox"/> Check here if Patient is deceased or incapable of signing.	Date

# Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

Name of Claimant \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

**2. Personal Information to be released:**

- data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
- any information regarding insurance or benefit plan coverage, claims or benefits; and/or
- any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

**3. You may release my Personal Information to:**

ATTN: Group Critical Illness/Specified Disease Management Services  
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company  
3300 Mutual of Omaha Plaza  
Omaha, NE 68175-0001  
or Fax: 402-997-1835 or Email: submitgrpci@mutualofomaha.com

**4. I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**

- to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
- to a vendor specializing in the application for Social Security Disability Benefits; or
- to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
- for self-insured disability plans only, to my employer; or
- for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
- as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

**RETAIN A SIGNED COPY FOR YOUR RECORDS**

Name(s) used for records (if different than the name below): \_\_\_\_\_

\_\_\_\_\_

Signature of Claimant

Date

**If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.**

**Printed Name of Legal Representative** \_\_\_\_\_

**Signature of Legal Representative** \_\_\_\_\_

**Type of Legal Representative** \_\_\_\_\_

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

**This page was left intentionally blank.**

**Authorization to Disclose Health Information to My Employer**

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer’s broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the critical illness/specified disease program provided under my Group critical illness/specified disease policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing critical illness/specified disease benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

**This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:**

**ATTN: Group Critical Illness/Specified Disease Management Services  
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company  
3300 Mutual of Omaha Plaza  
Omaha, NE 68175-0001**

**Or**

**Fax 402-997-1835**

**Or**

**Email submitgrpci@mutualofomaha.com**

**I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.**

**I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.**

\_\_\_\_\_  
(Printed Name and Address)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Or**

**If Applicable:** I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative \_\_\_\_\_

Signature of Legal Representative \_\_\_\_\_

Type of Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

**RETAIN A SIGNED COPY FOR YOUR RECORDS**



**This page was left intentionally blank.**

## Policyholder/Employer Statement

Employee/Member Name		Employee/Member SSN or ID Number
Patient Name (If not the Employee/Member)		Patient SSN or ID Number (If not the Employee/Member)
Patient Date of Birth (MM/DD/YYYY)	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)
Policyholder/Employer Name		Group ID Number G000 ____
City	State	ZIP Code
Email Address	Phone Number	Fax Number
Effective Date of Insurance for Employee/Member (MM/DD/YYYY)		
Employee/Member Benefit Amount (Elected/In Effect)		Patient benefit amount (Elected/In Effect, if applicable)
Was the Employee/Member or Patient previously insured under any other Critical Illness insurance policy offered through the Policyholder/Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>**A Copy of the Employee/Member's enrollment form/record and current beneficiary designation must be submitted with this claim.**</b>		
Class	Full-Time Employment Date (MM/DD/YYYY)	Avg. Hours Worked/Week
Does the Employee pay any premium for this insurance? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If Yes, what % of total premium is paid pre-tax by the Employee? _____ % Pre-Tax	
If the Employee is no longer working the minimum hours required under the policy, indicate why: <input type="checkbox"/> Termination <input type="checkbox"/> Layoff <input type="checkbox"/> Personal Leave of Absence <input type="checkbox"/> Medical Leave of Absence (e.g., FMLA) <input type="checkbox"/> Other (Explain):		
<b>Use this space to provide any additional information related to the information stated above, as needed:</b>		

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.

Signature of Policyholder/Employer Representative		Date
Printed Name		Title
Email Address	Phone Number	Fax Number

## Attending Physician Statement

Employee/Member Name	Employee/Member SSN or ID Number	Group ID Number G000 ____
Patient Name (If not the Employee/Member)	Patient SSN or ID Number (If not the Employee/Member)	
Patient Date of Birth (MM/DD/YYYY)	Patient Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee/Member (Write "Self" if Patient is the Employee/Member)

**Please check the illness/procedure for which this claim is being filed, and submit any relevant test results, hospital discharge summary and/or your detailed medical statements/records with this form, in addition to information indicated below:**

Illness/Procedure	Medical Documentation (As Applicable)	Additional Information	
<input type="checkbox"/> Heart Attack (Myocardial Infarction)	EKG, cardiac enzymes, biochemical markers, thallium scan, MUGA scan, echocardiogram, cardiac catheterization	Troponin T Level	Troponin I Level
<input type="checkbox"/> Heart Transplant/Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the Patient on the UNOS list? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide date added to list:	
<input type="checkbox"/> Heart Valve Surgery	EKG, X-ray, echocardiogram, cardiac catheterization, MRI, surgical report (open surgery required)		
<input type="checkbox"/> Coronary Artery Bypass	Angiogram, electrocardiogram (EKG), echocardiogram, stress test, EBCT, surgical report (open surgery required)		
<input type="checkbox"/> Aortic Surgery	Angiogram, CT, MRI, surgical report (open surgery required)		
<input type="checkbox"/> Stroke	Neuroimaging studies, documented neurological deficits	mRS Level:	
<input type="checkbox"/> Major Organ Transplant/Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the Patient on the UNOS list? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide date added to list:	
<input type="checkbox"/> End-Stage Renal Failure	Proof of regular dialysis	Does the patient have chronic, irreversible failure of both kidneys to function? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the Patient require dialysis at least weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Acute Respiratory Distress Syndrome (ARDS)	Arterial blood gas, X-ray, ARDS definition satisfied using the AECC, Murray LIS, Delphi or Oxygenation Index (OI) methods	P/F Ratio:	OI:
<input type="checkbox"/> Cancer (Invasive)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Rai or Binet Stage:
<input type="checkbox"/> Carcinoma in Situ	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	Clark Level:	Breslow Thickness:
<input type="checkbox"/> Skin Cancer (Basal or squamous cell carcinoma)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Breslow Thickness:
<input type="checkbox"/> Bone Marrow Transplant	Surgical report, proof of listing with NMDP		
<input type="checkbox"/> Benign Brain Tumor	Pathology report, CT, MRI, angiogram, MRA, surgery report		
<input type="checkbox"/> ALS (Lou Gehrig's) Disease	EMG NCV, X-ray, MRI, blood and urine studies, spinal tap, myelogram, neurological examination, muscle and/or nerve biopsy		
<input type="checkbox"/> Advanced Alzheimer's Disease	CT, MRI, PET, CSF, neurological examination	FAST Stage:	MMSE Score:
<input type="checkbox"/> Advanced Parkinson's Disease	CT, MRI, PET, neurological examination	Stage:	
<input type="checkbox"/> Cerebral Palsy (children only)	Formal diagnosis after age of 18 months		
<input type="checkbox"/> Structural Congenital Defect(s) (children only)	Diagnostic tests, clinical diagnosis		
<input type="checkbox"/> Genetic Disorder(s) (children only)	Genetic tests, clinical diagnosis		
<input type="checkbox"/> Congenital Metabolic Disorder(s) (children only)	GC/MS, blood tests, clinical diagnosis		
<input type="checkbox"/> Type 1 Diabetes (children only)	Blood tests, clinical diagnosis		

Diagnosis

ICD-9/10 Code	Date of Diagnosis (MM/DD/YYYY)	Date First Consulted (MM/DD/YYYY)
---------------	--------------------------------	-----------------------------------

Was Surgery Performed? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If Yes, provide CPT 4 codes:	*Date Surgery Performed (MM/DD/YYYY)
--	-------------------------------	--------------------------------------

Has the Patient ever had the same or similar illness(es)/procedure(s)? <input type="checkbox"/> Yes† <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is the Patient still under your care? <input type="checkbox"/> Yes <input type="checkbox"/> No‡	‡If No, final date of treatment (MM/DD/YYYY):
†If Yes, provide the date of prior illness(es)/procedure(s) and/or date of last treatment (MM/DD/YYYY):		

Attending Physician Name	Physician Phone Number	Physician Fax Number
--------------------------	------------------------	----------------------

Physician Street Address	Physician City	Physician State	Physician ZIP Code
--------------------------	----------------	-----------------	--------------------

Medical Specialty	Degree	Board Certification(s)
-------------------	--------	------------------------

Tax ID Number	Are you (the Attending Physician) related to the Patient? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If Yes, explain the relationship:
---------------	---	------------------------------------

**If the Patient was hospitalized for the Illness/Procedure stated above, provide hospital information:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason for Visit/Care	

**Provide information for any other hospital at which the Patient received care for the Illness/Procedure stated above:**

Hospital Name	Hospital Phone Number	Hospital Fax Number	
Hospital Street Address	Hospital City	Hospital State	Hospital ZIP Code
Date of Admission (MM/DD/YYYY)	Date of Discharge (MM/DD/YYYY)	Reason for Visit/Care	

**Provide information for the Patient's Primary Care Physician (Ex. Family Doctor or Pediatrician):**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code
Medical Specialty	Degree	Board Certification(s)	

**Provide information for any other treating Physician/Specialist for the Patient for the Illness/Procedure stated above:**

Physician Name	Physician Phone Number	Physician Fax Number	
Physician Street Address	Physician City	Physician State	Physician ZIP Code
Reason for Care			
Medical Specialty	Degree	Board Certification(s)	

**\*\*If the Patient was treated at more than two hospitals or by more than two additional physicians, provide the information required above for each hospital or physician either below or on a separate sheet of paper and submit it with this claim.\*\***

**Use this space to provide any additional information related to the information stated above, as needed:**

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information and statements provided on this form are true and complete to the best of my knowledge and belief.

Signature of Attending Physician

Date