

Transamerica Financial Life Insurance Company

National Employee Benefit Companies, Inc.
TRICARE CLAIM STATEMENT

INSTRUCTIONS: HOW TO SUBMIT A TRICARE CLAIM:

1. The form must be completed in full by Member and;
2. The reverse side must be completed by the claimant or claim delay may result.
3. Send the appropriate medical bills, hospital bills, and all Explanation of Benefit worksheets from TRICARE to:

Claims Department, WEB-TPA, P.O. Box 1868, Grapevine, TX 76099-1868

4. TRICARE Prime claimants must submit a receipt from the provider of care showing the co-payment amount.

Name Of Member:		Certificate Number:	Date of Birth:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____		
Address: (Street, City, State & Zip Code)			
Name of Patient:	Date of Birth:	Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Nature of Accident or Illness – Describe:			
Have you claimed benefits for this condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____			
Provide Name and Address of any Physician Contacted for this Condition.			
Name:		Name:	
Address:		Address:	

ASSIGNMENT OF BENEFITS

I hereby authorize payment of eligible benefits under my policy in connection with this injury or illness directly to (enter name of provider of care: hospital, doctor, etc.)

FRAUD WARNING NOTICES

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 violation.

X _____

Signature

Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient identified below. I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. You are hereby authorized to give to the Company specified below, or its representatives, copies of any records or data which have to do with the **physical or mental health including drug, alcohol, psychiatric, HIV infection or AIDS related treatment**. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date of Death: _____

Address: _____

Information to be disclosed to: **Transamerica Financial Life Insurance Company**
Or their Representative (EMSI, ScanTech Solutions and/or Lab ONE)

Disclose the complete records including the following information for treatment dates: _____ to _____:

- | | | | |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Consults | <input type="checkbox"/> Office Records | <input type="checkbox"/> Death Summary |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> Toxicology |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Autopsy |
| <input type="checkbox"/> Outpatient Reports | <input type="checkbox"/> Pathology | <input type="checkbox"/> EMS Report | <input type="checkbox"/> Medications |

The above information is disclosed for the purpose of processing an insurance claim.

I understand I may **revoke this authorization** at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization **expires 2 years from the date signed**; unless otherwise noted here: _____.

IMPORTANT – If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.
Initial here

_____ There is no court appointed Administrator/Executor and I am the next of kin.
Initial here

I understand that I am not required to sign this authorization. The above named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I also authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient named above, including financial institutions, and law enforcement agencies to give Transamerica Financial Life Insurance Company or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs.

Signature of Legal Representative

Date

Printed name of Legal Representative

Relationship or authority to act for Patient

Witness

Date

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS