

TO SIMPLIFY FILING YOUR CLAIM PLEASE FOLLOW THESE INSTRUCTIONS:

1. Answer only the questions that apply to your coverage.
2. Complete the authorization on the bottom of the form.
3. Ask your doctor to complete and sign his/her side of the form.
4. Send itemized bills for the benefits being claimed.

CLAIMANT'S STATEMENT

Physicians Mutual Insurance Company®

Patient's Name <input style="width: 90%;" type="text"/>		Date of Birth <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Death (if applicable) <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>
Policyowner's Full Name <input style="width: 60%;" type="text"/>	Patient's Relationship to Policyowner <input style="width: 40%;" type="text"/>	Date of Birth <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Phone Number <input style="width: 15%;" type="text"/> (<input style="width: 15%;" type="text"/>) - <input style="width: 25%;" type="text"/>		
Policyowner's Street Address <input style="width: 90%;" type="text"/>		Policy Number(s) <input style="width: 40%;" type="text"/>		<input style="width: 40%;" type="text"/>	
Policyowner's City <input style="width: 60%;" type="text"/>	State <input style="width: 10%;" type="text"/>	Zip <input style="width: 15%;" type="text"/>	<input style="width: 25%;" type="text"/>		<input style="width: 25%;" type="text"/>

Is this a New Address? Yes No

1. Hospital confinement	Admitted <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Discharged <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Hospital Name and Address <input style="width: 90%; height: 40px;" type="text"/>
2. Hospital intensive care unit	From <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	To <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	
3. Hospital outpatient care	From <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	To <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	
4. Skilled nursing or intermediate care facility	Admitted <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Discharged <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Nursing Facility Name and Address <input style="width: 90%; height: 40px;" type="text"/>
5. Home confined after hospitalization?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, confined until <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	
6. Is the claim for an accident?	Yes <input type="checkbox"/> → Describe the injury (How and where did the accident happen?) <input style="width: 90%; height: 30px;" type="text"/>		
7. Is the claim for a sickness?	Yes <input type="checkbox"/> → Describe the sickness <input style="width: 90%; height: 30px;" type="text"/>		
8. Date of the accident or first symptoms of the sickness	Doctor's Name and Address <input style="width: 90%; height: 40px;" type="text"/>		
9. Date a doctor was first seen			
10. Had any doctor been seen for this or a similar condition before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	If yes, Doctor's Name and Address <input style="width: 90%; height: 40px;" type="text"/>
11. Have you made a claim for Worker's Compensation?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
12. Do you have any other accident or sickness insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, list Name, Address and Benefits Provided <input style="width: 90%; height: 30px;" type="text"/>	

IF YOU HAVE A DISABILITY POLICY, PLEASE COMPLETE THIS SECTION (otherwise leave blank).

Date you quit work <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Employer's Name <input style="width: 80%;" type="text"/>
Date you resumed partial work <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Address <input style="width: 90%;" type="text"/>
Date you resumed full-time work <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Occupation <input style="width: 90%;" type="text"/>
If retired, when? <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Average Monthly Earnings <input style="width: 80%;" type="text"/>

SIGN BELOW AND HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE

Social Security Number <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>	AUTHORIZATION
Any physician, hospital, clinic, insurance company, employer or Government agency may release to Physicians Mutual Insurance Company, its affiliates, or its representatives or any consumer reporting agency representing them, any information or records (including copies) about insurance transactions, medical history/treatment and employment pertaining to me or my dependents as needed for claims administration. A copy of this authorization, which is valid only while my claim is pending, may be used in place of the original. My authorized representative or I have a right to a copy of this authorization upon request.	
Date: <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/> / <input style="width: 15%;" type="text"/>	Policyowner X <input style="width: 25%;" type="text"/>
	Patient X <input style="width: 25%;" type="text"/>

SEE ATTACHED FRAUD WARNINGS

ATTENDING PHYSICIAN PLEASE COMPLETE THIS SIDE

Patient's Name	Social Security Number	Date of Birth	Male	Female	Date of Death (if applicable)
			<input type="checkbox"/>	<input type="checkbox"/>	

ICD9/10-CM Codes				
Primary Diagnosis				
Secondary Diagnosis				

1. Was this the result of a sickness? Or an accident? Sickness Accident

2. Date of the accident or first symptoms of sickness / / →

Name/Address - Referring Physician

3. When were you first consulted for this condition? / /

4. Did the patient ever have the same or a similar condition before? Yes No →

Give Dates and Diagnosis and Name and Address of Physicians

5. Dates of hospital confinement	Admitted <input type="text"/> / <input type="text"/> / <input type="text"/>	Discharged <input type="text"/> / <input type="text"/> / <input type="text"/>	Hospital Name and Address
6. Dates in the intensive care unit	From <input type="text"/> / <input type="text"/> / <input type="text"/>	To <input type="text"/> / <input type="text"/> / <input type="text"/>	
7. Dates of hospital outpatient care	From <input type="text"/> / <input type="text"/> / <input type="text"/>	To <input type="text"/> / <input type="text"/> / <input type="text"/>	

8. Dates in skilled nursing or intermediate care facility	Admitted <input type="text"/> / <input type="text"/> / <input type="text"/>	Discharged <input type="text"/> / <input type="text"/> / <input type="text"/>	Nursing Facility Name and Address
9. Home confined after hospitalization? Yes <input type="checkbox"/> No <input type="checkbox"/> →	If yes, confined until <input type="text"/> / <input type="text"/> / <input type="text"/>		

10. Surgery information	Date Performed	CPT Code	Charge
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>

11. Other services	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>

12. Patient totally disabled	From <input type="text"/> / <input type="text"/> / <input type="text"/>	To <input type="text"/> / <input type="text"/> / <input type="text"/>
13. Patient partially disabled	From <input type="text"/> / <input type="text"/> / <input type="text"/>	To <input type="text"/> / <input type="text"/> / <input type="text"/>

14. Will a claim be presented for Worker's Compensation? Yes No

15. Have you reported to any other company? Yes No →

If yes, please identify

Physician's Signature Degree

Date / /

Street Address

City State Zip

Telephone () -

Physicians Tax Identification Number

To be used for IRS reporting

Fraud Warnings

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 a combination thereof.

Alaska

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Delaware, Idaho, Indiana and Oklahoma

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

District of Columbia and Maine

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.

Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire

Any person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

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 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.

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.

Ohio

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 guilty of insurance fraud.

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.

Tennessee, Virginia and Washington

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

All Other States

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.