NATIONAL FAMILY CARE LIFE INSURANCE COMPANY
P.O. BOX 809043 DALLAS, TEXAS 75380 (972) 387-8553

SAVE FORM TO COMPLETE

CLAIM FORM - HOSPITAL

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Check Claim Type(s): ☐ **Cancer** ☐ **Cancer-OP** ☐ **Heart** ☐ **Intensive Care Unit** ☐ **Emergency Rm** ☐ **Accident** ☐ **HIP Rider**

(The furnishing of this blank form or the preparation of proofs is not an acknowledgement of liability or waiver of the Company's rights.)

1. IDENTIFICATION

List all NFCL Policy #s

a. Patient's Name:________________________Date of Birth:____/____/________

b. Premium Payor:________________________(Relation to Patient)________________

c. Address: (Street)______________(City)__________(State)__________(Zip)__________

d. Social Security No.:________________________Phone No.: ________________

2. SICKNESS DESCRIPTION

a. Name of Condition?

(Description of Illness/accident)

b. Date of First Symptoms?
/ /

c. Have you had this or similar Sickness before? Yes No
If Yes, please supply Date(s):

3. DOCTORS INFORMATION

a. Date Doctor first consulted for this condition?

b. Names and Addresses of your Personal and Attending Physicians:

Name	Address	Date
•		
•		
•		

4. HOSPITAL INFORMATION

LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:

Hospital Name:____Date Admitted: __________
Address: (Street)______________________(City)______________________(ST)______ Date Released: __________

Hospital Name:____Date Admitted: __________
Address: (Street) (City) (ST) Date Released:

5. TREATMENT INFORMATION

DESCRIBE WHAT KIND OF TREATMENT YOU HAVE RECEIVED (Medical and/or Surgical) with DATES:

____

____

6. COMMENTS

PLEASE SUPPLY ANY ADDITIONAL INFORMATION THAT WILL ASSIST US IN PROCESSING YOUR CLAIM:

____

____

IMPORTANT: Every question must be fully answered. Use a separate sheet of paper if additional space is needed.
Send this form to NFCL as soon as possible.

Signed this__________day of______________, 20_____Patient's Signature ______________________________
(or Parent if under age 15)

Permanent mailing address of Premium Payor: (Street)______________________(City)______________________(ST)________(Zip)________

Business Phone: ____________________ Cell Phone: ____________________ Home Phone: ____________________
Area Code & Number Area Code & Number Area Code & Number

V.A. Claim No.____________________ Military Serial No. ____________________

Every Claim requires the completion of this **CLAIM FORM** and the attached **Medical Release Authorization Form** (for HIPAA Compliance).
In addition, also supply the required information for each specific claim type noted below:

- **CANCER** claims, include the attached Attending Physician Form, a Pathology Report, and an Admission & Discharge Summary.
- **CANCER-OP** claims, include the attached Attending Physician Form, a Pathology Report, and Outpatient Billings (chemo/radiation).
- **HEART ATTACK** claims, include the attached Attending Physician Form, an Admission & Discharge Summary, and EKG/Cath Report.
- **INTENSIVE CARE** claims, include an Itemized Hospital Statement.
- **ACCIDENT** claims, include the attached Attending Physician Form, and an Admission & Discharge Summary.
- **EMERGENCY ROOM** claims, include an Emergency Room Billing (showing date(s) and treatment(s)).
- **HIP RIDER** claims, include Admission & Discharge Summary and Past Medical History.

ATTENTION: This Claim Form is for you to complete. DO NOT leave it with your doctor or hospital. Answer all questions, sign and date, and return to us for processing!