



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

PRINT FORM TO COMPLETE

CLAIM FORM – HOSPITAL

PRINT FORM TO COMPLETE

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

(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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please supply Date(s): _____																					
3. DOCTORS INFORMATION																						
a. Date Doctor first consulted for this condition? _____																						
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="width: 30%; text-align: center;">Name</td> <td style="width: 30%; text-align: center;">Address</td> <td style="width: 10%; text-align: center;">Date</td> <td style="width: 10%; text-align: center;">Zip</td> </tr> <tr> <td>b. Names and Addresses of the Personal and Attending Physician:</td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>•</td> <td></td> <td></td> <td></td> </tr> </table>				Name	Address	Date	Zip	b. Names and Addresses of the Personal and Attending Physician:	•					•					•			
	Name	Address	Date	Zip																		
b. Names and Addresses of the Personal and Attending Physician:	•																					
	•																					
	•																					
4. HOSPITAL INFORMATION																						
LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:																						
Hospital Name: _____ Address: (Street) _____ (City) _____ (ST) _____		Date Admitted: _____ Date Released: _____																				
Hospital Name: _____ Address: (Street) _____ (City) _____ (ST) _____		Date Admitted: _____ Date Released: _____																				
5. TREATMENT INFORMATION																						
DESCRIBE KINDS OF TREATMENT THE DECEASED RECEIVED (Medical and/or Surgical) with DATES:																						
6. COMMENTS																						
PLEASE SUPPLEMENT 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____ Beneficiary/Owner _____
 (or Parent if under age 15)

Permanent mailing address of Premium Payor: _____

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

V.A. Claim No. _____ Military Serial No. _____

Every Claim require the completion of this **CLAIM FORM** and the attached **Medical Release Authorization Form** (for HIPPA 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 Billing (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, an Admission & Discharge Summary.
- **EMERGENCY RM** claims, include an Emergency Room Billing (showing date(s) and treatment(s)).

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