



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

SAVE FORM TO COMPLETE

**CLAIM FORM - HOSPITAL**

SAVE FORM TO COMPLETE

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.)

<b>1. IDENTIFICATION</b>		<b>List all NFCL Policy #s</b>
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.: _____		
<b>2. SICKNESS DESCRIPTION</b>		
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):	
<b>3. DOCTORS INFORMATION</b>		
a. Date Doctor first consulted for this condition?		
b. Names and Addresses of your Personal and Attending Physicians:		
	Name	Address Date
	•	_____
	•	_____
	•	_____
<b>4. HOSPITAL INFORMATION LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:</b>		
Hospital Name: _____		Date Admitted: _____
Address: (Street) _____ (City) _____ (ST) _____		Date Released: _____
Hospital Name: _____		Date Admitted: _____
Address: (Street) _____ (City) _____ (ST) _____		Date Released: _____
<b>5. TREATMENT INFORMATION DESCRIBE WHAT KIND OF TREATMENT YOU HAVE RECEIVED (Medical and/or Surgical) with DATES:</b>		
_____		
_____		
<b>6. COMMENTS PLEASE SUPPLY ANY ADDITIONAL INFORMATION THAT WILL ASSIST US IN PROCESSING YOUR CLAIM:</b>		
_____		
_____		

**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!