# 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**

(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?

_____

| | 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:** _____ **Date Admitted:**_____
**Address:** **(Street)**_____**(City)**_____**(ST)**_____ **Date Released:**_____

**Hospital Name:** _____ **Date Admitted:**_____
**Address:** **(Street)**_____**(City)**_____**(ST)**_____ **Date Released:**_____

## 5. TREATMENT INFORMATION

**DESCRIBE KINDS OF TREATMENT THE DECEASED RECEIVED (Medical and/or Surgical) with DATES:**

## 6. COMMENTS

**PELASE SUPPLE 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: _____ Cell Phone: _____ Home Phone: _____
Area Code & Number Area Code & Number 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!