NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

Health Insurance

PATIENT STATEMENT

INSTRUCTIONS:

- **ANSWER ALL QUESTIONS COMPLETELY**
- **ATTACH ALL HOSPITAL BILLS**
- **YOUR DOCTOR MUST COMPLETE AND SIGN THE REVERSE SIDE**

1. Insured's Name: _____Male:____ Female_____ Date of Birth: _____/_____/_____

   Address: _____Apt. No._____

   City: _____State:_____ _____Zip:_____

2. Policy No. _____ Certificate No. _____ Social Security No. _____/_____/_____

3. Claimant's Name, if other than insured: _____Male: ____Female: ____ Date of Birth: ____/____/____

4. Describe illness or injury: _____

5. If accident, give details: _____

6. Date condition first noticed _____/_____/_____ Date doctor first seen _____/_____/_____

7. Have you had the same or similar condition before? Yes ☐ No ☐ If yes, give details:

_____

8. Names and addresses of attending physician(s) _____

_____

9. Name and address of family physician: _____

10. Describe any other illness or injury requiring medical attention in the past 2 years and give name and address of doctor(s) who treated you: Condition: Doctor's name and address:

_____

_____

_____

11. List all other insurance coverage you have:

_____

_____

I authorize any physician, medical practitioner, hospital, clinic other medical care institution, insurance support organization, governmental agency, or insurance company to release any and all medical information and its possession about me or my minor children to National Benefit Life insurance Company or its legal representatives for the length of time of this coverage. Medical information means all information in the possession off or derived from providers of health care regarding the advice, care or treatment of me or my minor children.

I understand that this information will be used by National Benefit Life Insurance Company for the purpose of evaluating my claim for insurance benefits.

I know that I may request a copy of this authorization.

I agree that this authorization shall be valid for the term of the coverage of the policy.

I agree that a photocopy of this authorization shall be as valid as the original.

The following statement is made in accordance with the Insurance Laws: 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.

Claimant sign here: _____ Date: _____/_____/_____
(If a minor, parent or guardian must sign)

Insured sign here: _____ Date: _____/_____/_____

Insured Telephone No.: _____

Return to: **National Benefit Life Insurance Company**
30-30 47th Avenue, Suite 625
Long Island City, NY 11101-3433

1. MEDICARE ☐ *(Medicare #)* **MEDICAID** ☐ *(Medicaid #)* **CHAMPUS** ☐ *(Sponsor's SSN)* **CHAMPVA** ☐ *(VA file #)* **GROUP HEALTH PLAN** ☐ *(SSN or ID)* **FECA BLK LUNG** ☐ *(SSN)* **OTHER** ☐ *(ID)*

1a. INSURED'S I.D. NUMBER **(FOR PROGRAM IN ITEM 1)**

2. PATIENT'S NAME *(Last Name, First Name, Middle Initial)*

3. PATIENT'S DATE OF BIRTH MM DD YY **SEX** M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No. Street)

CITY | **STATE**

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | **STATE**

ZIP CODE | **TELEPHONE (Include Area Code)** ( )

ZIP CODE | **TELEPHONE (Include Area Code)** ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY **SEX** M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY **SEX** M ☐ F ☐

b. OTHER CLAIM ID

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OF PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *(If yes, return to and complete item 9a-d)*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below:

SIGNED:

14. DATE OF CURRENT: MM DD YY ← **ILLNESS** (First symptom) OR **INJURY** (Accident) OR **PREGNANCY** (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO **$CHARGES**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1.2.3 OR 4 TO ITEM E BY LINE)

A. _____ B. _____ C. _____ D. _____

E. _____ F. _____ G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

22. MEDICAID RESUBMISION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I ID QUAL	J RENDERING PROVIDER ID #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims see back) ☐ YES ☐ NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signed Date

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RSS1500

PLEASE PRINT OR TYPE

NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800- 800-222-2062

PLEASE RETURN THIS FORM WITH YOUR CLAIM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

For Use and Disclosure of Protected Health Information

By my signature below:

(1) I authorize National Benefit Life Insurance Company, its affiliates (collectively the "Company"), reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive my health information;
(2) I acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes;
(3) I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose my health information;
(4) I acknowledge that this Authorization may be relied upon to determine my eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company;
(5) I acknowledge that this Authorization expires two (2) years from the date it is signed;
(6) I acknowledge that I may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself;
(7) I acknowledge that if I refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however, the Company may not be able to process this application or, if coverage is issued, process this claim or make any benefit payments;
(8) I acknowledge that information disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy of health information; and
(9) I acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of my signature, is valid as the original and I may receive a copy of this Authorization after it is signed.

Insured: _____Policy Number: _____

Signature of Claimant: _____Date: _____