MEDMUTUAL PROTECT™
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
P.O. Box 9988 Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: mailto:ProtectGRPService@MedMutual.com

CANCER AND SPECIFIED DIESEASE WELLNESS CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within one (1) year from the date of service.
- Please complete Claim Form and mail, fax or email the completed form to the address or fax number indicated above.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please provide all bills associated with your claim, including treatment dates, total charges, diagnoses, and procedure codes and/or itemized bills: HCFA 1500 or UB-92.

Insured/Claimant Information

Insured's Name *(Last, First, Middle)*	Policy/Certificate #	Social Security No.	Date of Birth	Sex

Address *(Street, City, State, Zip)*		
Phone Number *(With Area Code)*	Email	
Claimant's Name	Date of Birth	Relationship to Insured

Wellness Screening

Please check the appropriate wellness screening and provide itemized bill.

- ☐ Abdominal aortic aneurysm ultrasound
- ☐ Blood test for triglycerides
- ☐ Bone marrow testing
- ☐ Bone density screening
- ☐ Breast ultrasound
- ☐ CA 15-3 (blood test for breast cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Carotid ultrasound
- ☐ CEA (blood test for colon cancer)
- ☐ Chest x-ray
- ☐ Colonoscopy
- ☐ CT Angiography
- ☐ EKG
- ☐ Double contrast barium enema
- ☐ Fasting blood glucose test
- ☐ Flexible sigmoidoscopy
- ☐ Hemoccult stool analysis
- ☐ Mammography
- ☐ Pap Smear
- ☐ PSA (blood test for prostate cancer)
- ☐ Serum cholesterol HDL/LDL
- ☐ Serum protein electrophoresis (blood test for myeloma)
- ☐ Stress Test
- ☐ Thermography

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

INSURED'S SIGNATURE:		DATE:	
CLAIMANT'S SIGNATURE:		DATE:	