KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

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WELLNESS BENEFIT CLAIM FORM UNDER CANCER/SPECIFIED DISEASE COVERAGE

Instructions to File a Claim:

- Please complete Insured/Claimant Statement, You may also mail, email, or fax the completed form.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating patient name, date of service, name of provider, type of service, and diagnosis code.

Insured/Claimant Statement

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)		
Claimant's Name	Date of Birth	Relationship to Insured		

Please click the appropriate wellness screening and provide itemized bill.

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

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 AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____