THE Great-West Life ASSURANCE COMPANY

Great-West Life your Benefits Solutions People

CANUS, UNICARE HEALTH AND ACCIDENT CLAIM FORM

SECTION A — TO BE COMPLETED BY EMPLOYEE

1	GROUP POLICY NUMBER **UC 106269**		PLAN NAME: **CANUS**		
2	NAME OF EMPLOYEE		EMPLOYEE SOCIAL SECURITY NO.	SEX ☐ M ☐ F	BIRTHDATE
3	ADDRESS OF EMPLOYEE: NO. & STREET	CITY	STATE	ZIP	
4	TELEPHONE NO.	DATE YOU LAST WORKED	HAS YOUR EMPLOYMENT TERMINATED? ☐ YES ☐ NO	IF YES, WHEN?	
5	IF MARRIED, YOUR SPOUSE'S FIRST NAME IS SPOUSE EMPLOYED? ☐ YES ☐ NO	SPOUSE'S DATE OF BIRTH	NAME AND ADDRESS OF SPOUSE'S EMPLOYER	SS# OF SPOUSE	
6	COMPLETE LINES 5, 6 & 7 FOR DEPENDANT CLAIMS ONLY — NAME OF DEPENDANT	☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	SEX ☐ M ☐ F	BIRTHDATE	CERTIFICATE/I.D. NO. (if any)
7	ADDRESS OF DEPENDANT PATIENT	SS# OF DEPENDANT	SCHOOL/EMPLOYER (if any) OF DEPENDANT	ADDRESS OF SCHOOL	
8	HAVE YOU (OR YOUR DEPENDANT) VISITED A DOCTOR OR TAKEN PRESCRIPTION MEDICINE FOR THIS CONDITION BEFORE DATES SHOWN BY YOUR DOCTOR ON THIS FORM? ☐ YES ☐ NO	IF YES, NAME AND ADDRESS OF DOCTOR	DATES OF TREATMENT		
9	DO YOU OR YOUR FAMILY MEMBERS HAVE ANY OTHER GROUP INSURANCE FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO	IF YES, PROVIDE (A) INSURANCE CO. (B) EMPLOYER (C) POLICY NO. AND I.D. NO.			
10	IS CONDITION DUE TO ACCIDENTAL INJURY? ☐ YES ☐ NO	IF YES, WAS THE INJURY CAUSED BY THE ACT OR OMISSION OF A PERSON OTHER THAN YOURSELF? ☐ YES ☐ NO	PLACE OF ACCIDENT ☐ AUTO ☐ WORK ☐ HOME ☐ OTHER	DATE OF ACCIDENT	

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE TO OR BY UNICARE LIFE & HEALTH INSURANCE COMPANY OR ITS REPRESENTATIVE OF ANY HOSPITAL, MEDICAL, OR OTHER INSURANCE INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDANTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED.

▶ _____
SIGNATURE (Patient or Parent, if Minor) DATE

SECTION B — HOSPITAL ASSIGNMENT

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE HOSPITAL FOR WHOSE CHARGES CLAIM IS BEING MADE OF ANY GROUP INSURANCE BENEFITS AVAILABLE FOR THESE CHARGES. I UNDERSTAND I AM RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

▶ _____
EMPLOYEE'S SIGNATURE DATE

HOW TO FILE YOUR CLAIM

Important
Use this form for medical expenses other than vision and prescription drugs. For visioncare claims, use a UniView® VisionSM Reimbursement Form. For prescription drug claims, use CANUS, UniCare Prescription Drug Claim Form. Forms are available on www.greatwestlife.com.

Any person who knowingly and with intent to defraud of deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject or criminal penalties.

1. **COMPLETE SECTION A.** Answer all questions. **YOU MUST INCLUDE EITHER YOUR SOCIAL SECURITY NUMBER OR THE ID# SHOWN ON YOUR CARD.**
2. **HAVE YOUR DOCTOR COMPLETE SECTION C** and return it to you for submission to your claim office. If your plan includes Employee Weekly Disability benefits, be sure line 4 above is answered.
3. **ADDITIONAL MEDICAL BILLS:** Attach these to the completed claim form. After initial claim submission, complete the first 4 questions in Section A and attach additional bills. **A NEW DOCTOR'S STATEMENT IS NOT NECESSARY IF THE DIAGNOSIS OF THE CONDITION BEING TREATED IS ON THE BILL**. A detailed bill may be included if you do not follow "4" below.

   SUBMIT ITEMIZED BILLS. Do not send cancelled checks, cash register receipts, or lists prepared by you. The actual bills are needed. Prescription receipts must show the pharmacy, prescription number, date of purchase and the name of the person for whom drugs are purchased. Charges subject to a policy deductible may be accumulated, and submitted when their total satisfies the deductible amount. You do not have to submit each bill as it is incurred.
4. **HOSPITAL ADMISSION:** (Optional - see above) – Complete Sections A and B. Present your identification card with your form and claim office envelope to the hospital admissions clerk. Ask the hospital to return the form with a detailed hospital bill to the claim office. The hospital may wish to contact the claim office to verify your coverage. **NOTE** – In case of hospital confinement, 2 forms may be needed, one for the hospital and one for the doctor.
5. **WHERE TO SEND YOUR CLAIM: Group Claims, UNICARE, PO Box 819, Buckeystown, MD, 21717. Tel. No.: 1.800.365.9036**. New forms are available on the Great-West Life corporate website: www.greatwestlife.com.

SECTION C — ATTENDING PHYSICIAN'S STATEMENT

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

NOTE: RETURN COMPLETED FORM TO THE EMPLOYEE

PATIENT & EMPLOYEE INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME (First name, middle name, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX ☐ M ☐ F	6. EMPLOYEE'S SS# or **ID#.** (include any letters)
	7. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	8. EMPLOYEE'S GROUP NO. **UC 106269**
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN AUTO ACCIDENT ☐ YES ☐ NO	11. EMPLOYEE'S ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the Release of any Medical Information Necessary to Process this Claim.

SIGNATURE _____ DATE _____

13. I authorize payment of Medical Benefits to undersigned, physician or supplier for services described below.

SIGNATURE (Employee or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM | THROUGH	DATES OF PARTIAL DISABILITY FROM | THROUGH
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED | DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

24. A DATE OF SERVICE	B* Place of Service	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (Identify)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D Diagnosis	E CHARGES	F

25. Signature & Certification of Physician or Supplier: (I certify that the number shown on this form is my correct taxpayer identification number and I am not subject to backup withholding.) SIGNATURE _____ DATE _____	26. ACCEPT ASSIGNMENTS (Government claims only) ☐ YES ☐ NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	I.D. NO.		

*PLACE OF SERVICE CODES

1 – (H) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY
6 – NIGHT CARE FACILITY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
0 – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACILITY
C – EMERGENCY ROOM

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