



Claim Submission Instructions for CCPOA Members

- 1) Be sure to complete the appropriate sections of the claim form and provide all requested information.
- 2) Have the physician treating you complete the Attending Physician's Statement on page 2.
- 3) If loss of time is claimed, have your employer or school complete the Employer Statement on page 1.
- 4) If medical or hospital benefits are claimed, itemized bills must be attached. Make sure the claimant's name is on each attachment.
- 5) Be sure to sign the claim form on the bottom of page 1.
- 6) **Fax both pages of the claim form and any itemized bills to 312-351-6930.** Faxing will expedite the processing of your claim.
- 7) You should receive status of your claim within 7 to 10 business days of our receipt of your claim form.

Questions about your claim? Call 1-866-445-8865

Fax both pages of this form to: 312-351-6930.

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement to state prison.

PLEASE PRINT—DO NOT WRITE

CLAIMANT'S FULL NAME, E-MAIL ADDRESS, HOME PHONE, BUSINESS PHONE, MAILING ADDRESS, POLICY NUMBER(S), PLAN NUMBER(S), LAST PAYMENT DATE, BIRTH DATE, HEIGHT, WEIGHT, Is claimant eligible for Medicaid or a similar state program?, OCCUPATION, CCPOA Benefit Trust Fund, ARE YOU ALSO FILING CLAIM UNDER WORKERS' COMP. ACT?, IF YOU HAVE OTHER ACCIDENT, SICKNESS OR HOSPITAL INSURANCE, GIVE COMPANY NAME

IF CLAIM IS FOR SICKNESS, DATE OF FIRST SYMPTOMS, HAVE YOU EVER HAD SAME OR SIMILAR CONDITION?, IF YES, GIVE DATE, NATURE OF SICKNESS, PLEASE COMPLETE

IF CLAIM IS FOR ACCIDENTAL INJURY ("ACCIDENT"), DATE OF ACCIDENT, TIME OF ACCIDENT, NATURE OF INJURIES, PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED: PLEASE COMPLETE

PLEASE COMPLETE FOR BOTH ACCIDENT AND SICKNESS CLAIMS, HOSPITAL'S NAME, ADDRESS, CITY, STATE, CONFINEMENT DATES, ATTENDING PHYSICIANS' NAMES AND ADDRESSES, DATES OF TREATMENT, A) TOTAL DISABILITY, B) DATE RETURNED TO WORK, C) PARTIAL DISABILITY

EMPLOYER'S STATEMENT (If student, please have school principal complete), COMPLETE ONLY IF CLAIMING LOSS OF TIME, EMPLOYEE'S NAME, WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY?, NAME AND ADDRESS OF COMPENSATION CARRIER, DATE RETURNED TO WORK (OR SCHOOL), TOTAL DISABILITY, PARTIAL DISABILITY, DATE, TITLE, EMPLOYER'S SIGNATURE, TELEPHONE

AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, Prescription Drug Database, insurance company, state and federal government agency, the Internal Revenue Service, employer, consumer reporting agency or the MIB (Medical Insurance Bureau) to release to Combined Insurance Company of America any information for the purpose of processing a claim. Combined is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATED: MO. DAY YR.

SIGNED: X CLAIMANT'S SIGNATURE (If Minor, Parent's Signature)

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME

ADDRESS (Street, City, State, Zip)

AGE

<p>1. NATURE AND ORIGIN OF:</p> <p><input type="checkbox"/> SICKNESS</p> <p><input type="checkbox"/> INJURY</p>	<p>DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)</p> <p style="text-align: right;">CONFIRMED BY X-RAY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?</p>	<p>DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p>
<p>3. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?</p>	<p>DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p>
<p>4. HOW DID CONDITION ORIGINATE?</p>	
<p>5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES", STATE WHEN AND DESCRIBE.)</p>	<p><input type="checkbox"/> YES DESCRIBE CONDITION:</p> <p><input type="checkbox"/> NO</p>
<p>6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.</p>	
<p>7. GIVE DATE AND NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCRIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)</p>	<p>DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p> <p>NATURE OF PROCEDURE:</p> <p>APPROACH USED:</p> <p style="text-align: right;">CLOSED REDUCTION? <input type="checkbox"/></p> <p style="text-align: right;">OPEN REDUCTION? <input type="checkbox"/></p> <p style="text-align: right;">METAL FIXATION? <input type="checkbox"/></p>
<p>8. GIVE DATE OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL.</p>	<p>DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p> <p>NATURE OF TREATMENT:</p> <p style="text-align: right;">OFFICE <input type="checkbox"/></p> <p style="text-align: right;">HOSPITAL <input type="checkbox"/></p> <p style="text-align: right;">HOME <input type="checkbox"/></p>
<p>9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY.</p>	<p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO DISCHARGE DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p> <p style="text-align: right;">RECOVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>10. IF PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL.</p>	<p>HOSPITAL</p> <p>ADDRESS CITY STATE</p> <p>FROM/...../..... THROUGH/...../.....</p> <p style="text-align: center;">MO. DAY YR. MO. DAY YR.</p>
<p>11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED?</p>	<p>FROM/...../..... THROUGH/...../.....</p> <p style="text-align: center;">MO. DAY YR. MO. DAY YR.</p>
<p>12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?</p>	<p>FROM/...../..... THROUGH/...../.....</p> <p style="text-align: center;">MO. DAY YR. MO. DAY YR.</p>
<p>13. IF PATIENT IS DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? (IF "YES", GIVE RETURN TO WORK DATE.)</p>	<p><input type="checkbox"/> YES RETURN TO WORK DATE/...../.....</p> <p style="text-align: center;">MO. DAY YR.</p> <p><input type="checkbox"/> NO</p>

PHYSICIAN'S SIGNATURE	DEGREE
COMPLETE ADDRESS	
DATE	TELEPHONE
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE	
INDIVIDUAL PRACTITIONER'S S.S. NUMBER	ALL OTHERS - EMPLOYER I.D. NUMBER
+	+