Critical IllnessPLUS®
Cancer CarePLUS®

Provider Claim Form
Diagnosis of Cancer

This form to be completed by Attending Physician providing care for this condition. PLEASE PRINT

Form Completed by:	Date:
Patient's Name:	
Date of Birth: _____ / _____ / _____	Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Insurance ID Number:	

History

1. Diagnosis: _____

2. Date of Diagnosis: _____ / _____ / _____
   Month Day Year

3. Diagnostic Codes: _____

Is metastatic disease present? ☐ Yes ☐ No

Please describe: _____

_____

_____

Please include a copy of diagnostic test results or operative and/or pathology result reports that support this diagnosis. If no supporting pathology report exists, please provide documentation of diagnosis, supporting information and current plan of treatment.

Name of Physician:_____ Specialty: _____

Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

I certify that the above information is complete and accurate to the best of my knowledge.

_____ _____
Physician Signature Date

FRAUD WARNING STATEMENT

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

Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Residents of New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Residents of Pennsylvania: 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 subjects such person to criminal and civil penalties.

Residents of Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Residents of All Other States: For your protection, state law requires the following statement to appear on this form: WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The furnishing of forms does not constitute an admission of liability on the part of the Company.

PLEASE RETURN COMPLETED FORM TO:

American Republic Insurance Company
Attention: Policy Claims
601 6th Avenue P.O. Box 10
Des Moines, Iowa 50301-0010