Humana

Critical Illness and Supplemental Health – Health Screening Benefit Claim Filing Instructions

Page One – Filing Instructions

- Complete the appropriate sections of the claim form (page 2).
- Submit to the address, fax to the number below or e-mail.

Page Two – Critical Illness and Supplemental Health – Health Screening Benefit Claim Form

- Must be completed each time to file a claim.
- The claim must include either sections II & III completed and signed by your physician or an itemized billing from your provider that includes the date of service and service(s) provided (cpt codes).

- Before sending your claim form, please be sure you have included all items listed above to prevent delay in processing of your claim.
- Retain a copy of all information submitted for your records.

If you have any questions when completing this form, please call 1-877-378-1505.

Mail to the following address:

Kanawha Insurance Company
A Humana company
P.O. Box 2000
Lancaster, SC 29721-2000

Or FAX to:
1-502-405-7107

Or Email to:
VBClaimsSubmission@Humana.com

California
County of Stanislaus Group #7210391000
Includes: $100 Health Screening Benefit
$200 Mammography Screening Benefit

Humana.

Critical Illness and Supplemental Health – Health Screening Benefit Claim Form

This claim form can be used to request reimbursement for your Health Screening Benefits under your Critical Illness plan.
You can either have your physician complete and sign the information below or attach documentation from the provider indicating the date of service, and the service provided (description or CPT code).

Submission of the Health Screening benefit claim form is not a guarantee of payment. Plan requirements do vary and coverage will be based on your policy provisions. Additional information may be required. Most Critical Illness plans require services be provided more than 90 days after the effective date in order to be eligible for coverage. However, these limitations can vary per plan. Review your plan for more information on the specific information on the wellness/health screening benefits and applicable claims waiting periods.

Section I – Member Information:

Is the claim for the: ☐ Policyholder ☐ Dependent

Policyholder's Name _____ Policy No. _____

Street Address_____ Social Security No. _____

City _____ State _____ ZIP Code _____ Date of Birth ____ /____/_____

Daytime Telephone No. (_____)_____

Claimant Name _____ Date of Birth ____ /____/_____

Section II – Provider Information:

Printed Name of Physician _____ Phone No. (_____) _____

Street Address_____ Specialty _____

City _____ State _____ ZIP Code _____

Signature of Physician_____ Date _____ /_____/_____

Section III – Service Information:

Please check all services provided below:

- ☐ Bone Marrow testing
- ☐ Chest X-ray
- ☐ Flexible Sigmoidoscopy
- ☐ Pap Smear
- ☐ Biopsy for Skin Cancer
- ☐ Lipid Plan
- ☐ CA 15-A (for Breast Cancer
- ☐ CEA (Colon Cancer)
- ☐ Hemocult Stool Analysis
- ☐ PSA (Prostate Cancer)
- ☐ Stress Test (bike or treadmill)
- ☐ Blood test for Triglycerides
- ☐ CA-125 (Ovarian Cancer)
- ☐ Colonoscopy
- ☐ Mammography (including ultrasound)
- ☐ Serum Protein Electrophoresis
- ☐ Electrocardiogram (EKG)
- ☐ Oral Cancer Screening using ViziLite, OraTest or other current dental code D0431

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 3)

The above statements are true to the best of my knowledge and belief.

_____ ____ /____/_____
Signature of Policyholder *Date*

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Lancaster, SC 29721-2000

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Email: VBClaimsSubmission@Humana.com