CLAIM REQUIREMENTS

National Family Care Life
13530 Inwood Rd
Dallas, Tx 75244
972-387-8553

CANCER CLAIMS
Claim Form
HIPAA Authorization
Attending Physician
Pathology Report
Admission & Discharge Summary

CANCER OUTPATIENT CLAIMS
Claim Form
HIPAA Authorization
Attending Physician
Pathology Report
Outpatient Billings(chemo/rad)

HEART ATTACK CLAIMS
Claims Form
HIPAA Authorization
Attending Physician Form
Admission and Discharge Summary
EKG/Cath Report

INTENSIVE CARE CLAIMS
Claim Form
HIPAA Authorization
Itemized Hospital Statement

ACCIDENT CLAIMS
Claim Forms
HIPAA Authorization
Attending Physician
Admission and Discharge Summary

EMERGENCY ROOM CLAIMS
Claim Forms
HIPAA Authorization
Emergency Room Billing
show charges, dates and treatment)

LIFE CLAIMS
Claim Forms
HIPAA Authorization
Certified Death Certificate

ATTENTION!
This Claim Form is for you to complete. DO NOT leave it with your doctor or hospital. You MUST answer all questions and sign and date this form and return it to our office in order for us to process your claim. THANK you

NATIONAL FAMILY CARE LIFE INSURANCE COMPANY
13530 INWOOD ROAD DALLAS, TEXAS 75244 (972) 387-8553

CLAIM FORM

CHECK TYPE(S) OF CLAIM: ☐ Cancer ☐ Cancer—OP ☐ Heart ☐ Intensive Care Unit ☐ Emergency Room ☐ Accident ☐ Life

(The furnishing of this blank or the preparation of proofs is not an acknowledgement of liability or waiver of the Company's rights.)

1. IDENTIFICATION:

a. Patient's Name: _____ Date of Birth: _____

b. Premium Payor: _____ (Relation to Patient) _____

c. Address: (Street) _____ (City) _____ (State) _____ (Zip) _____

d. Social Security No.: _____ Phone No.: _____

List all NFCL Policy Nos.

2. SICKNESS DESCRIPTION:

a. Name of Condition?
(Description of Illness/accident)

_____

b. Date First Symptoms?

c. Have you had this or similar Sickness before? If yes, when? Yes_____ No_____ Date_____ 19_____

3. DOCTORS INFORMATION:

a. Date Doctor first consulted for this condition

Date _____ 19_____

b. Names and addresses of your Personal & Attending Physicians

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

4. HOSPITAL INFORMATION

LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:

Name of Hospital: _____ Date Admitted: _____

Address of Hospital: (Street) _____ City_____ State_____ Date Released: _____

Name of Hospital: _____ Date Admitted: _____

Address of Hospital: (Street) _____ City_____ State_____ Date Released: _____

5. TREATMENT INFORMATION

What kind of treatment have you received (Medical and/or surgical)? _____

Describe and give Dates _____

6. COMMENTS

IMPORTANT: Every question must be fully answered. Use a separate piece of paper if additional space needed. Send form to Company at earliest Date.

Signed this _____ day of _____, 20 ____ Patient's Signature _____
(or Parent if under age 15)

Permanent mailing address of Premium Payer, Street _____ City_____ State_____ Zip_____

Business Phone: _____ Home Phone: _____
Area Code & Number Area Code & Number

V.A. Claim No. _____

Military Serial No. _____

******IMPORTANT NOTICE******

Please complete the attached Medical Release or we will not be able to assist you in obtaining Medical Records from hospital. Must list dates admitted and released.

ATTENTION!

This Claim Form is for you to complete. DO NOT leave it with your doctor or hospital. You MUST answer all questions and sign and date this form and return it to our office in order for us to process your claim.

THANK YOU

NATIONAL FAMILY CARE LIFE INSURANCE COMPANY

13530 INWOOD ROAD DALLAS, TEXAS 75244 (214) 387-8553

☐ **IMPORTANT—PLEASE NOTE:** **LIFE: 1. Beneficiary answers all questions on this form and returns. 2. Death Certificate. 3. Return Policy. ☐ Yes ☐ No**

CLAIM FORM

Complete all the information in the block checked.

(The furnishing of this blank or the preparation of proofs is not an acknowledgement of liability or waiver of the Company's rights.)

1. IDENTIFICATION:

a. Name of Deceased: _____ Date of Birth: _____ Date of Death: _____

b. Beneficiary Relationship to Deceased: _____

c. Address of Deceased (Street) _____ (City) _____ (State) _____

d. Address of Beneficiary (Street) _____ (City) _____ (State) _____

List all NFCL Policy Nos.

2. CAUSE OF DEATH: _____

a. Illness: ☐ Yes ☐ No

b. Accident: ☐ Yes ☐ No

c. Police Report Filed: ☐ Yes ☐ No

If Yes, list name of Police Department, State, County and Address:

_____

_____

d. Date First Symptoms? _____

e. Has deceased had this or similar illness before? If yes, when? Yes _____ No _____ Date _____ 19____

3. DOCTOR'S INFORMATION:

a. Date Doctor first consulted for this condition: Date _____ 19____

b. Personal Physician and Attending Physician(s):

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

c. Name and address of Doctor who made last Electrocardiogram: Name _____ (Street) _____ (City) _____ (State) _____

4. HOSPITAL INFORMATION

LIST ALL HOSPITAL CONFINEMENTS FOR TREATMENT OF THIS CONDITION:

Name of Hospital: _____ Date Admitted: _____

Address of Hospital: (Street) _____ City _____ State _____ Date Released: _____

Name of Hospital: _____ Date Admitted: _____

Address of Hospital: (Street) _____ City _____ State _____ Date Released: _____

5. TREATMENT INFORMATION

a. What kind of treatment has deceased received (Medical and/or surgical)?

Describe and give dates _____

b. List names of any drugs taken in last two years and give dates first taken.

Drug _____ Date _____ 19____

Drug _____ Date _____ 19____

6. COMMENTS

IMPORTANT: Every question must be fully answered. Use a separate piece of paper if additional space needed. Send form to Company at earliest Date.

Signed this _____ day of _____, 19____ Beneficiary/Owner _____

Permanent mailing address of Premium Payer (Street) _____ (City) _____ (State) _____ (Zip) _____

Business Phone: _____ Area Code & Number

Home Phone: _____ Area Code & Number

V.A. Claim No. _____

AUTHORIZATION STATEMENT

Military Serial No. _____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my past or present health, to give to the National Family Care Life Insurance Company, Dallas, Texas, any such information that they desire. I hereby waive all provisions of law forbidding the disclosure of such information.

(To facilitate rapid submission of such information, I authorize all said sources, to include but not limited to Retail Credit Company, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information.) A photographic copy of this authorization shall be as valid as the original.

Form 2XXCF 4/86 Date _____, 19____

_____

Signature: Beneficiary/Owner

NATIONAL FAMILY CARE LIFE INSURANCE COM PANY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize_____to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus("HIV") and Acquired Immune Deficiency Syndrome("AIDS"), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that treatment or payment cannot be conditioned on my signing of this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. **This authorization will expire one hundred and eighty(180) days from the date of my signature, Unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability act of 1996.

Print patient name date of birth social security number

Dates of service_____

Description of information to be released:(check all that apply)

_____DISCHARGE SUMMARY	_____HISTORY&PHYSICAL	_____OPERATIVE REPORT
_____ITEMIZED BILL	_____CARDIAC CATHERIZA	_____PROGRESS NOTES
_____CONSULTATION REPRT	_____ER RECORD	_____PATHOLOGY REPRT

****THE PURPOSE OF THIS DISCLOSURE IS INSURANCE PURPOSES****

PLEASE FORWARD ALL REQUESTED INFORMATION TO: **National Family Care Life**
13530 Inwood rd
Dallas, Tx 75244
800-527-0996

_____ _____
SIGNATURE **DATE**

_____ _____
PRINT SIGNATURE **RELATIONSHIP TO PATIENT**

PLEASE RETURN THIS FORM TO NFC CLAIMS DEPARTMENT, DO NOT LEAVE AT HOSPITAL

NATIONAL FAMILY CARE LIFE INSURANCE COMPANY
P.O. BOX 809043 DALLAS, TEXAS 75380 (972) 387-8553

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	BIRTHDATE	Street Address _____ City _____ State _____ Zip _____

PRIMARY DIAGNOSIS? (Must include ICD-9 code.)	
Date of Accident ? (If applicable)	
Date patient first consulted you for this condition?	
Date patient first noted symptoms before consulting you?	
List medications patient has taken for this condition in past 2 years.	
Has patient received consultation or treatment for this condition in the past year?	
Has patient ever had same or similar condition? Yes _____ No_____ If yes, when and describe.	
Please describe the pain (character, location, etc.) and the associated symptoms and findings (shock, dyspnea, arrythmia, failure, etc.).	
What special studies were made (ECG, X-ray, etc.) ? When? What were the results?	
Dates of Hospital Confinement?	From _____ To _____
Is any medication being taken (digitalis, anti-coagulants, coronary dilator drugs, etc.) ? Yes _____ No _____ If yes, please give type and dosage.	

DATE _____ PHYSICIAN'S NAME _____ DEGREE _____
(Please Print)

ADDRESS _____ _____ _____ _____
(Street) (City) (State) (Zip)

TELEPHONE _____ _____ PHYSICIAN'S SIGNATURE _____
(AC) (Number)