How to File a Critical Illness Claim

CONCIERGE Third Party Administrator

Attached is a claim form for your Critical Illness benefit.

Please provide:

- A fully completed Claim Form is required for each condition. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form is not an admission of coverage. We reserve the right to obtain additional information, as needed, to evaluate the claim.

Part 1 – Policyholder / Patient Information

Employee Information

Employer Name		
Name (First, Middle, Last) ☐ Male ☐ Female		
Street Address		
City	State	Zip Code
EE#	Date of Birth	

Patient Information Check One: ☐ Spouse ☐ Child ☐ Self

Name (First, Middle, Last) ☐ Male ☐ Female		
Street Address		
Street Address	State	Zip Code
EE#	Date of Birth	

Part 2 – Illness / Condition Information

What type of illness are you claiming?		
Primary Doctor Name		
Street Address		
City	State	Zip Code

When where you first treated for this illness (Date mm/dd/yy)		
Treating Doctor Name		
Street Address		
City	State	Zip Code

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Part 3 – Authorizations

I authorize payments to be made to the named Employee Plan Member of the Group Employee Health Plan.

Signature of Authorized Signer (Required)	Date Signed (MM/DD/YYYY)
X	

If applicable, I signed on behalf of the insured as _____ (indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

Signature of Authorized Signer (Required)	Date Signed (MM/DD/YYYY)
X	

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the plan member to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **Concierge Administrative Services, LLC**. or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Signature of Authorized Signer (Required)	Date Signed (MM/DD/YYYY)
X	

If applicable, I signed on behalf of the insured as _____ (indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

Signature of Authorized Signer (Required)	Date Signed (MM/DD/YYYY)
X	

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Part 4 - Attending Physician Statement

Patient's Name (first, middle initial, last name)	Patient's Date of Birth	Patient's Address (street, city, state, ZIP code)
Patient's Sex ☐ Male ☐ Female	Patient's Relationship to Insured: ☐ Spouse ☐ Child ☐ Self	
Date of Diagnosis:	Date first consulted you for this condition:	Has this patient previously had had same or similar condition: ☐ Yes ☐ No If yes, show first treatment date(s)
Name of referring or other treating physicians	For services related to hospitalization, provide hospitalization dates Admit: Discharge:	
Name and address of facility where services rendered (if other than home or office)		
Diagnosis or nature of illness or injury:		
Physician Signature: X	Date:	

Please check the condition that applies to this patient and provide a complete copy of the patient's medical records.

☐ Cancer	☐ End Stage Renal Failure	☐ Major Organ Transplant	☐ Occupational HIV
☐ Carcinoma in situ	☐ Heart Attack	☐ Permanent Paralysis	☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Coronary Artery Bypass Surgery	☐ Heart Transplant	☐ Stroke	☐ Blindness

Please forward claims and questions to the following address:

Concierge Administrative Services, LLC.
P.O. Box 4070
Bartlesville, OK 74006
P: 888-820-5687
F: 918-333-9505