Standard Claim Form

Use this form to submit a claim and request reimbursement when the provider does not submit the claim. Claim forms can be submitted via mail or fax to the address and phone number listed on this form. For help please contact customer service at 800-654-9106. For more information, visit **MedMutualProtect.com/Individual**

MedMutual PROTECT™
A Medical Mutual® Company

PO Box 21531 Eagan, MN 55121
Customer Service: 800-654-9106
Fax: 877-877-0078

Section 1: Claimant's Statement

To be completed personally by the claimant or policy owner.

Claimant name	Address	City	State	Zip code	Date of birth (MM/DD/YYYY)

Policy number(s)

What type of claim(s) are you filing?

☐ Accident	☐ Sickness	☐ Wellness
Date of accident (MM/DD/YYYY)	Date of first symptoms (MM/DD/YYYY)	Date of service (MM/DD/YYYY)
Have you filed for worker's comp? ☐Yes ☐No	Date of first doctor visit (MM/DD/YYYY)	What type of service was rendered?
Was this the result of an auto accident? ☐Yes ☐No		

Have you had symptoms or treatment for this sickness before? If yes complete section below.

Symptoms or treatment date (MM/DD/YYYY)	Doctor name	Doctor address
Symptoms or treatment date (MM/DD/YYYY)	Doctor name	Doctor address

INITIAL

Authorization for medical release

I hereby authorize any hospital, physician or other provider, insurer or other third-party payer or the medical information bureau to furnish to Reserve National Insurance Company, Oklahoma City, Oklahoma, or its representative, or permit said insurance company, or its representative, to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. **The information authorized for release may include information about communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).** A photostatic copy of this authorization shall be considered as valid as the original. I declare the above answers and statements true and correct to the best of my knowledge and belief.

INITIAL

Authorization to pay physician

I hereby authorize payment directly to the attending physician for this illness or injury, of the physician's or surgeon's benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I understand i am financially responsible to the physician for charges not covered by this assignment.

Claimant signature (if 18 or older)	**Date** (MM/DD/YYYY)
Policy owner signature (only if Claimant is under 18)	**Date** (MM/DD/YYYY)

Section 2: Medical Provider Report

Patient's name	Address	City	State	Zip code	Date of birth (MM/DD/YYYY)

Health care services

Diagnosis description(s)	Diagnosis code(s)	Diagnosis code(s)	Date of onset (MM/DD/YYYY)
Procedure description(s)	Procedure code(s)	Procedure code(s)	Date of treatment (MM/DD/YYYY)

Date first consulted (MM/DD/YYYY)	Due to pregnancy ☐Yes ☐No	Compensation case ☐Yes ☐No	When, in your opinion, did patient first become aware of some symptom of this condition?
If hospitalized, name and address of hospital		Date admitted (MM/DD/YYYY)	Date discharged (MM/DD/YYYY)
Name and address of other physicians who have treated patient for this illness or injury			

Physician signature		**Physician degree**		**Date** (MM/DD/YYYY)
EIN or TIN	**Address**	**City**	**State**	**Zip code**

Insurance benefits provided by **Reserve National Insurance Company**

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Notice to Arkansas Residents
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Residents
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. 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.

Notice to Kentucky Residents
WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Notice to Louisiana Residents
NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maryland Residents
NOTICE: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Mexico Residents
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to Oklahoma Residents
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Pennsylvania Residents
NOTICE: 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

Notice to Texas Residents
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 in state prison.