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#### EMPLOYEE'S STATEMENT

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.					
1. SUBSCRIBER'S NAME	2. SUBSCRIBER'S CONTRACT NUMBER				

3. HOME ADDRESS: street, city, state and zip code							
4. PATIENT'S NAME		5. DATE OF BIRTH		6. AGE	7. SEX		
					М	F	
8. PATIENT'S RELATIONSHIP TO SUBSCRIBER		9. SUBSCRIBER'S TELEPHONE					
self spouse child		home: work:					
10. TYPE OF ILLNESS/INJURY, OR DOCTOR'S DIAGNOSIS:							
PHYSICIAN'S NAME AND ADDRESS							
NAME OF HOSPITAL, IF CONFINED	DATE	DATE ADMITTED		DATE DISCHARGED			
DATE ACCIDENT OR SICKNESS BEGAN		WAS CONDITION RELATI	ED TO:				
month day year		AC	CIDENT				
DATE FIRST TREATED		ILI	NESS				
month day year							

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to give Southland National Insurance Corporation or Benefit Administrators any additional information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Date:\_\_

Subscriber's Signature:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A STATEMENT 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.

#### ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS A	AND CONCURRE	ENT CONDITIONS							
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIE			UT OF PATIEN	Γ'S EMPLOYMENT?	ILLNESS?	ACCIDENT?			
				YES 🗌 NO 🗌	YES 🗌 NO 🗌	YES 🗌 NO 🗌			
3. REPORT OF S	SERVICES (OR A	TTACH ITEMIZED BILL)							
(IF PREVIOU	S FORM SUBMIT	TED TO THIS CARRIER, YOU	NEED SHOW	ONLY DATES AND SERV	ICES SINCE LAST REPORT)				
DATES OF SI	ERVICES	PLACE OF SERVICES		DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED					
4. DATE PATIEN	DATE PATIENT CONSULTED YOU FOR THIS CONDITION 5. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?					ONDITION?			
					YES NO				
PHYSICIAN'S N	NPI #			PHYSICIAN'S T.I.N. or S	SSN #				
DATE	PHYSICI	AN'S NAME (PRINT)	SIGN	I ATURE	DEGREE	TELEPHONE			
STREET ADDRI	ESS		CITY	OR TOWN	STATE	ZIP CODE			

# HOW TO FILE A CLAIM

# TO ASSURE PROMPT AND ACCURATE HANDLING OF YOUR CLAIMS, FOLLOW THESE 5 SIMPLE STEPS:

### STEP 1

Complete this form as soon as possible.

# STEP 2

Fill in every question completely and accurately.

# STEP 3

Ask doctor to complete Physician's Statement and return to you.

## STEP 4

Attach itemized copy of hospital bill. Please provide a UB04 (UBzero4) or a 1500 form

# STEP 5

Mail this form with a copy of your hospital bill to:

Southland Benefits Administration P.O. Box 1250 Tuscaloosa, Alabama 35403

## NOTE:

PLAN DOES NOT COVER OUTPATIENT TREATMENT FOR ILLNESS.