Trustmark
benefits beyond benefits

Critical Illness / Cancer Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

ATTENDING PHYSICIAN'S STATEMENT (Page 1 of 3)	***PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION***
Policy Owner Name:	Patient's Name (First, MI, Last):
Your Patient's Acct #:	Patient's DOB:
Patient's Relationship to Employee ❑ Self ❑ Spouse ❑ Child	
Patient's or Authorized Person's Signature	**Date Signed**

PHYSICIAN OR SUPPLIER STATEMENT *Please entire form. Sign & date this form on page 3.*		
Date of Diagnosis	Date 1st consulted you for this condition	Has patient previously had same or similar condition: ❑ Yes ❑ No If yes, show 1st treatment date(s)
Name of referring or other treating physicians	For services related to hospitalization, provide hospitalization dates Admit: Disch:	
Name and address of facility where services rendered (if other than home or office)		
Diagnosis or nature of illness or injury:		
Please complete section(s) for all condition(s) that apply to this patient and provide the test results, operative reports, pathology reports, and/or our detailed medical statements as required for the condition indicated below:		

ALS *Attach test results*
Diagnosis established by: ☐ MRI ☐ Nerve biopsy ☐ EMG ☐ Neurological exam Date of DX:

Blindness What was vision at last observation? *(Snellen Notation)*

With glasses: O.D. _____ O.S. _____ Date:

Without glasses: O.D. _____ O.S. _____ Date:

Date corrected vision was irrecoverably reduced to 20/400 or less or VF less than 20 degrees in the better eye: _____ ☐ O.D. ☐ O.S.

Cancer/Carcinoma in Situ

Date and documented exact pathologic diagnosis: _____

If clinically diagnosed, date, reason, treatment recommended:

Coronary Artery Bypass

Date of CAD diagnosis: _____ Degree of obstruction: _____ Date of Surgery: _____

Trustmark
benefits beyond benefits

Critical Illness / Cancer Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

ATTENDING PHYSICIAN'S STATEMENT (Page 2 of 3)

Policy Owner Name:	Patient's Name (First, MI, Last):

End Stage Renal Failure

Does the patient have end stage renal failure presenting as chronic, irreversible failure to function of both kidneys? ☐ Yes ☐ No

Does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly) or which results in kidney transplantation? ☐ Yes ☐ No

Is the patient on UNOS (United Network for Organ Sharing) list for a transplant? ☐ Yes ☐ No

Date of diagnosis as End Stage (Level V) Renal Failure: _____

Heart Attack Does the patient's condition meet all of the following criteria:

Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? ☐ Yes ☐ No

Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK) or elevated troponins? (If "Yes", attach confirmatory lab reports) ☐ Yes ☐ No

Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? ☐ Yes ☐ No

(Attach copies of any applicable reports)

Major Organ Failure

Did the patient undergo surgery to receive a human heart, liver, both lungs or pancreas? (attach a copy of the operative report) ☐ Yes ☐ No

If operation has not been performed, is patient on UNOS (United Network for Organ Sharing) list for a transplant? ☐ Yes ☐ No

What condition caused the need for the major organ transplant? _____

Occupational HIV

Did the patient contract HIV at work and while performing normal occupational duties, from one of the following? ☐ Accidental Needle Stick ☐ Other Accidental Sharp Injury
☐ Accidental Mucous Membrane Exposure to Blood or Bloodstained Bodily Fluid (Attach lab results)

Permanent Paralysis

Did the patient have total and permanent loss of use of 2 or more limbs due to accident or sickness? ☐ Yes ☐ No
Date Initial: _____ Date and results of last exam: _____
Cause of paralysis: _____

Stroke

Initial objective neurologic deficit: _____
Imaging and result: _____
If persistent objective neurologic deficit 30 or more days, please describe:
_____
Date of initial diagnosis: _____ Date of last neurologic exam: _____

Trustmark
benefits beyond benefits

Critical Illness / Cancer Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

ATTENDING PHYSICIAN'S STATEMENT (Page 3 of 3)

Policy Owner Name:	Patient's Name (First, MI, Last):

PHYSICIAN INFORMATION AND SIGNATURE

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Print or Type Name		Degree		Medical Specialty
Street Address		Telephone #		Fax #
City	State	Zip Code		SSN or Employer's ID #:
Signature of Physician				**Date Signed**

Please provide name & phone number for Office Manager or other person to contact if additional information is needed:
Name(please print): _____ Phone: _____

Are you, the physician, related to this patient? ❑ Yes ❑ No If yes, what is the relationship?	May we communicate with you via email? ❑ Yes ❑ No If yes, Email Address: _____