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	***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 complete, sign & date this form where indicated.*		
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 check the condition that applies to this patient and provide the test results, operative reports, pathology reports, and/or your detailed medical statements as required for the condition indicated below: (Check all that apply)

Applies?	**Condition**	**Medical Documentation Needed**
☐	Cancer: Stage _____ Grade _____	Pathology Report
☐	Carcinoma in situ	Pathology Report and/or Clinical Diagnosis
☐	Coronary Artery Bypass Surgery	Open heart surgical report
☐	End Stage Renal Failure	Regular hemodialysis and/or Peritoneal dialysis
☐	Heart Attack	Any of the following: Electrocardiogram (EKG), Cardiac enzymes, Thallium scans, MUGA scans, Stress Echocardiogram
☐	Major Organ Transplant	Surgical Records
☐	Stroke	Documented neurological deficits and/or Neuroimaging studies
☐	Permanent Paralysis	Clinical diagnosis
☐	Occupation HIV	Incident Report, blood tests
☐	Amyotrophic Lateral Sclerosis (ALS)(Lou Gehrig's disease)	Medical reports, Neurological reports
☐	Blindness	Ophthalmologists Report

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**
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: _____	