Trustmark
benefits beyond benefits

Critical HealthEvents – Specified Illness Claim

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

ATTENDING PHYSICIAN STATEMENT (To Be Completed By Attending Physician)

Patient's Name:	Patient's DOB: / /

Date patient **first reported symptoms** or accident happened: _____

Date of 1st Treatment: _____ Date of subsequent treatments: _____, _____, _____, _____,

Is this condition due to: an Accident ☐ a Sickness ☐ ?

Did another physician refer this patient to you? Yes ☐ No ☐

If yes, please list name, address, and specialty: _____

Patient's Condition - Please check off ***Primary Diagnosis*** and list ***Date of Diagnosis*** below:

Check illness being claimed	Specified Illness	Date of Diagnosis
☐	**Blindness** - Permanent loss of visual acuity, without expectation for improvement, based on either: 1. Best corrected visual acuity of 20/400 or worse, or 2. Visual field of 20 degrees or worse in the better eye **Date of Diagnosis** - the date a licensed ophthalmologist physically examines and certifies that the definition of Blindness is met.	
☐	**Complications of Diabetes** - diabetes causes an amputation of a lower limb, which includes all areas at or above the forefoot, as a result of the diabetic condition. **Date of Diagnosis** - the date of surgery when amputation occurs	
☐	**Loss of Hearing** - Clinically proven irreversible loss of hearing in both ears, with anticipated best corrected auditory threshold of more than 90 decibels, through surgery, hearing aid, device, or implant. **Date of Diagnosis** - the date on which a licensed audiologist physically examines and certifies that the definition of Loss of Hearing is met.	
☐	**Major Organ Failure** - Failure of one of the following major organs: liver, lung, pancreas, or heart. **Date of Diagnosis** - the date placed on a medically accredited transplant list for a transplant.	
☐	**Occupational Human Immunodeficiency Virus (HIV)** - The contracting of HIV caused by a needle stick or sharp injury or mucous membrane exposure to blood or bloodstained bodily fluid. **Date of Diagnosis** - the date on which the follow-up blood test results are received which confirm the diagnosis of HIV.	
☐	**Paralysis** - Clinical Diagnosis of a complete and irreversible condition marked by loss of muscle function in two or more limbs (paraplegia, quadriplegia, hemiplegia) as the direct result of an illness or disease, which is not expected by a Physician to reverse or resolve.	

More conditions on next page; please be sure to sign and date the next page.

Trustmark
benefits beyond benefits

Critical HealthEvents – Specified Illness 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 (Continued)

Patient's Name:	Patient's DOB:

Check illness being claimed	Specified Illness	Date of Diagnosis
☐	**Renal Failure** - Chronic renal failure, which is the irreversible failure of the function of both kidneys such that regular dialysis is required to sustain life. **Date of Diagnosis** - the date the physician determines the presence of chronic irreversible failure or both kidneys.	
☐	**Central Nervous Condition** - Lupus, Sarcoid, or central nervous infection of the brain which leads to brain damage resulting in neurological impairment which is objectively measured, is confirmed by neuroimaging studies, and a medical professional has determined that neurological impairment resulted from the condition currently being diagnosed and was not previously present, and has persisted for 30 days or longer.	
☐	**Complications of Diabetes** - Life threatening complications due to diabetes characterized by: 1. Extreme hyperglycemia and dehydration, and 2. A Physicians determination that immediate hospitalization is necessary. **Date of Diagnosis** - the date of hospitalization.	
☐	**Stem Cell/ Bone Marrow Transplant** - When there is infusion or injection of healthy stem cells into the body to replace damaged or diseased stem cells. **Date of Diagnosis** - the date the stem cell or bone marrow infusion or injection is received.	

Please provide Clinical or Diagnostic findings (including the results of X-rays, EKG's, laboratory data, pertinent physical examination notes, etc.)_____

_____

Has patient been hospital confined? ❑ Yes ❑ No If Yes, From _____ To _____

If yes, Hospital name: _____

Is patient competent to endorse checks and direct the use of proceeds thereof? ❑ Yes ❑ No

Are you, the physician, related to this patient? ❑ Yes ❑ No If yes, what is the relationship?_____

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____

_____ _____

Degree *Specialty*

Phone: _____-_____-_____ Fax: _____-_____-_____

Address: _____

May we communicate with you using email? ❑ Yes ❑ No

If yes, Email Address: _____