KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988
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ACCIDENT AND HEALTH SCREENING CLAIM FORM

Instructions to File a Claim:

- Please complete Insured/Claimant Statement. You may also mail, email, or fax the completed form and attachments.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating patient name, date of service, name of provider and type of service.
- If an insured person is also covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means that instead of paying the benefits to the insured, we must pay the benefits to Medicaid or the medial provider to reduce the charges billed to Medicaid.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Address (Street, City, State, Zip)		Phone Number (With Area Code)		
Claimant's Name	Date of Birth	Relationship to Insured		

Please check the accident and health screening undergone by claimant and provide itemized bill.	
Accident Risk Screening Test (including one or more of:)	
Epworth Sleepiness Scale	Visual acuity test
Drug/alcohol abuse assessment/screening	Hearing acuity test
Standard neurological exam (or portion of such exam:)	Baseline testing for concussions
Mental status testing	Bone density screening
Cranial nerve exam	Chest X-ray
Sensorimotor testing	EKG
Cerebellar testing	Stress test
Gait/balance assessment	Annual physical examination
Pediatric development testing	Other (specify): ________________________
Hemoglobin A1c	

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN 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 DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE__________________________ INSURED'S SIGNATURE: ____

DATE__________________________ CLAIMANT'S SIGNATURE: ____