

FAX 1-800-880-9325

P. O. Box 100195
Columbia, SC 29202-3195



Please complete the section that applies to you.
Please allow two weeks after mailing your claim for us to process.

Please sign and return the enclosed authorization and the certification to avoid delay.

Express Filing of Cancer Screening/Wellness Benefit

For express filing, you must send the following information from your doctor:

- The type of cancer wellness screening that was performed, date of service, and copy of bill.
- If you are treated at a non-cost incurred facility, please furnish verification from the facility of the date and type of test performed.

This claim is for Self Spouse Dependent

1. Policyholder Name (First, Middle, Last)		Patient Name-if not self (First, Middle, Last)	
Policyholder Social Security Number		Patient Social Security Number	
Birthdate (mm/dd/yyyy)		Birthdate (mm/dd/yyyy)	
Address (Street/Apt #)			<input type="checkbox"/> Check Here If New Address
City	State	Zip	Home Phone # ()
2. Policyholder email address:			
3. Type of Test Performed*			Date Test Performed (mm/dd/yyyy)
4. Doctor's Name		Doctor's Phone # ()	
		Doctor's Fax # ()	
5. Doctor's Address (Street)	(City)	(State)	(Zip Code)

*Please Note: Your policy(ies) does not provide benefits for routine physical examinations. Please review your policy(ies) for the list of covered tests.

CERTIFICATION

Policyholder/Employee's Name _____ Social Security Number _____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form.

DATE (mm/dd/yyyy)

POLICYHOLDER/EMPLOYEE SIGNATURE

PATIENT SIGNATURE