Nippon Life Benefits®

Medical Claim - CA

Please mail completed form to:
Nippon Life Benefits
Attn: Claim Center
P.O. Box 25951
Shawnee Mission, KS 66225-5951

- **Most** claims are filed by doctors and hospitals and you may not need a form. If your doctor or hospital requires one, complete this form and send it to the address above.
- Provide information as indicated to avoid delay in the processing of this claim.
- For verification of coverage, the provider should call the Benefit Phone # on the ID Card.

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Part A. Employee Information

Employee's name (first, middle, last) | **Plan and I.D. numbers (printed on I.D. card)** Plan I.D. | Employee's birth date

Employee's employer | Employee's employment date | Is employee still working? ☐ yes ☐ no | If "no," give date last worked

Is employee
☐ single ☐ married ☐ domestic partner ☐ separated ☐ divorced ☐ widowed

Part B. Patient Information (Complete a separate form for each patient.)

For whose expenses is claim being made? (If patient is other than self, answer questions 1-8 in this section.)
☐ self (If "self," go to questions 4, 5, 6, 7, 8) ☐ wife ☐ husband ☐ domestic partner ☐ son ☐ daughter ☐ stepchild ☐ foster child

1. Patient's birth date | 2. Patient's name (first, middle, last)

3. Patient's occupation

4. This claim is the result of ☐ illness ☐ injury | 5. Is it employment related? ☐ yes ☐ no | 6. Date occurred | 7. If injury, place it happened

8. Describe illness/injury

Part C. Other Insurance Information

(Complete if: a. this is the first claim for this illness or injury - or –
b. you have not submitted a completed claim form in the last six months.)

If employee is married, give spouse's or domestic partner's name (if other than patient) | Spouse's or domestic partner's birth date (if other than patient)

Spouse's or domestic partner's social security number | Is spouse or domestic partner employed? ☐ yes ☐ no

If "yes," give name, address and telephone number of spouse's or domestic partner's employer.

If "yes," does spouse's or domestic partner's employer provide group medical coverage? ☐ yes ☐ no | If "yes," please list any family members covered by this plan?

If "no," please explain

If patient is covered by any other medical plan, group policy, prepayment plan, Medicare or other government plan, please provide the following information:

Name of person(s) carrying the other coverage | Name of group (employer, association, etc.)

Policy or plan number | Name and address of insurance company or plan

These statements are true and complete to the best of my knowledge.

▶ Signature of employee | Date signed

Print

Part D. Authorization for Release of Information (Complete for every claim.)

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Nippon Life Insurance Company of America (Nippon Life Benefits) and the planholder, or their representatives, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

▶ Signature of employee | Date signed

▶ Signature of patient (required if patient is spouse or domestic partner) | Date signed

Address of employee (street) | (city)

(state) | (ZIP code) | Is this a new address? ☐ yes ☐ no | Please furnish a daytime telephone number in case we need to reach you.

Authorization to Pay (Sign here only if you want benefits paid directly to patient's doctor, hospital, or other provider of medical care.)

I authorize payment of medical benefits to physician or supplier for service described below or on attached bill.

▶ Signature of authorized person | Date signed

In order for this claim to be processed accurately an itemized statement must be attached. An itemized statement must include the provider's name and address, dates and types of services, charges, patient's name and diagnosis.