

Mailing Address:
P.O. Box 1250
Tuscaloosa, Alabama 35403



EMPLOYEE'S STATEMENT

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

1. SUBSCRIBER'S NAME		2. SUBSCRIBER'S CONTRACT NUMBER	
3. HOME ADDRESS: street, city, state and zip code			
4. PATIENT'S NAME		5. DATE OF BIRTH	6. AGE
		7. SEX M <input type="checkbox"/> F <input type="checkbox"/>	
8. PATIENT'S RELATIONSHIP TO SUBSCRIBER self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/>		9. SUBSCRIBER'S TELEPHONE home: _____ work: _____	
10. TYPE OF ILLNESS/INJURY, OR DOCTOR'S DIAGNOSIS: 			
PHYSICIAN'S NAME AND ADDRESS			
NAME OF HOSPITAL, IF CONFINED		DATE ADMITTED	DATE DISCHARGED
DATE ACCIDENT OR SICKNESS BEGAN month _____ day _____ year _____		WAS CONDITION RELATED TO: ACCIDENT _____ ILLNESS _____	
DATE FIRST TREATED month _____ day _____ year _____			

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to give Southland National Insurance Corporation or Benefit Administrators any additional information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Date: _____ Subscriber's Signature: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS			
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?		ILLNESS?	ACCIDENT?
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)			
DATES OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
4. DATE PATIENT CONSULTED YOU FOR THIS CONDITION		5. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PHYSICIAN'S NPI #		PHYSICIAN'S T.I.N. or SSN #	
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE
_____	_____	_____	_____
STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE
_____	_____	_____	_____

HOW TO FILE A CLAIM

TO ASSURE PROMPT AND ACCURATE HANDLING OF YOUR CLAIMS, FOLLOW THESE 5 SIMPLE STEPS:

STEP 1

Complete this form as soon as possible.

STEP 2

Fill in every question completely and accurately.

STEP 3

Ask doctor to complete Physician's Statement and return to you.

STEP 4

Attach itemized copy of hospital bill.

STEP 5

Mail this form with a copy of your hospital bill to:

Southland Benefits Administration
P.O. Box 1250
Tuscaloosa, Alabama 35403

NOTE:

PLAN DOES NOT COVER OUTPATIENT TREATMENT FOR ILLNESS.