Physicians Mutual®
Insurance for all of us.®

Claim Services
PO Box 2018
Omaha, NE 68103-2018
Toll-free Number 1-800-228-9100
Omaha Number 402-633-1111
Claim Fax Number 1-402-633-1088

TO SIMPLIFY FILING YOUR CLAIM PLEASE FOLLOW THESE INSTRUCTIONS:

1. Answer only the questions that apply to your coverage.
2. Complete the authorization on the bottom of the form.
3. Ask your doctor to complete and sign his/her side of the form.
4. Send itemized bills for the benefits being claimed.

CLAIMANT'S STATEMENT **Physicians Mutual Insurance Company®**

Patient's Name **Date of Birth** / / **Male** **Female** **Date of Death (if applicable)** / /

Policyowner's Full Name **Patient's Relationship to Policyowner** **Date of Birth** / / **Phone Number** ( ) –

Policyowner's Street Address **Policy Number(s)**

Policyowner's City **State** **Zip**

Is this a New Address? ☐ **Yes** ☐ **No**

1. Hospital confinement — **Admitted** / / **Discharged** / / → **Hospital Name and Address**
2. Hospital intensive care unit — **From** / / **To** / / →
3. Hospital outpatient care — **From** / / **To** / / →
4. Skilled nursing or intermediate care facility — **Admitted** / / **Discharged** / / → **Nursing Facility Name and Address**
5. Home confined after hospitalization? ☐ **Yes** ☐ **No** → **If yes, confined until** / /
6. Is the claim for an accident? ☐ **Yes** → **Describe the injury (How and where did the accident happen?)**
7. Is the claim for a sickness? ☐ **Yes** → **Describe the sickness**
8. Date of the accident or first symptoms of the sickness / /
9. Date a doctor was first seen / / → **Doctor's Name and Address**
10. Had any doctor been seen for this or a similar condition before? ☐ **Yes** ☐ **No** → **If yes, when** / / → **If yes, Doctor's Name and Address**
11. Have you made a claim for Worker's Compensation? ☐ **Yes** ☐ **No**
12. Do you have any other accident or sickness insurance? ☐ **Yes** ☐ **No** → **If yes, list Name, Address and Benefits Provided**

IF YOU HAVE A DISABILITY POLICY, PLEASE COMPLETE THIS SECTION (otherwise leave blank).

Date you quit work / / Employer's Name
Date you resumed partial work / / Address
Date you resumed full-time work / / Occupation
If retired, when? / / Average Monthly Earnings

SIGN BELOW AND HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE

Social Security Number — —

AUTHORIZATION

Any physician, hospital, clinic, insurance company, employer or Government agency may release to Physicians Mutual Insurance Company, its affiliates, or its representatives or any consumer reporting agency representing them, any information or records (including copies) about insurance transactions, medical history/treatment and employment pertaining to me or my dependents as needed for claims administration. A copy of this authorization, which is valid only while my claim is pending, may be used in place of the original. My authorized representative or I have a right to a copy of this authorization upon request.

Date: / / Policyowner **X** Patient **X**

SEE ATTACHED FRAUD WARNINGS

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ATTENDING PHYSICIAN PLEASE COMPLETE THIS SIDE

Patient's Name | **Social Security Number** — — | **Date of Birth** / / | **Male** | **Female** | **Date of Death** (if applicable) / /

ICD9/10-CM Codes
Primary Diagnosis
Secondary Diagnosis

1. Was this the result of a sickness? Or an accident? ☐ Sickness ☐ Accident
   Name/Address – Referring Physician
2. Date of the accident or first symptoms of sickness / /
3. When were you first consulted for this condition? / /
   Give Dates and Diagnosis and Name and Address of Physicians
4. Did the patient ever have the same or a similar condition before? **Yes** ☐ **No** ☐
5. Dates of hospital confinement — **Admitted** / / **Discharged** / / — **Hospital Name and Address**
6. Dates in the intensive care unit — **From** / / **To** / /
7. Dates of hospital outpatient care — **From** / / **To** / /
8. Dates in skilled nursing or intermediate care facility — **Admitted** / / **Discharged** / / — **Nursing Facility Name and Address**
9. Home confined after hospitalization? **Yes** ☐ **No** ☐ — **If yes, confined until** / /
10. Surgery information

Date Performed	CPT Code	Charge
/ /		
/ /		
/ /		

11. Other services

/ /		
/ /		

12. Patient totally disabled — **From** / / **To** / /
13. Patient partially disabled — **From** / / **To** / /
14. Will a claim be presented for Worker's Compensation? **Yes** ☐ **No** ☐
15. Have you reported to any other company? **Yes** ☐ **No** ☐ — **If yes, please identify**

Physician's Signature | **Degree** | **Street Address**

Date / / | **City** | **State** | **Zip**

Telephone ( ) —

Physicians Tax Identification Number
To be used for IRS reporting

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Fraud Warnings

Alabama

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison or a combination thereof.

Alaska

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia and Maine

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Kentucky and Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim 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 and subjects such person to criminal and civil penalties.

Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire

Any person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio

Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Tennessee, Virginia and Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.