Humana Insurance Company
CLAIM FORM FOR WELL CARE BENEFIT

For prompt consideration, all itemized bills from all providers must be attached.

CLAIM FOR: ☐ **Well Care Benefit**

INSURED NAME	ADDRESS (CITY, STATE, ZIP)
DATE OF BIRTH SOCIAL SECURITY NO.	TELEPHONE NO. POLICY NUMBER
PATIENT NAME	DATE OF BIRTH SOCIAL SECURITY NO.

1. If Claim is on Dependent, please answer the following:
   Claim is on ☐ Dependent spouse; ☐ Dependent Child
   Does the Claimant meet definition of covered person under the policy? ☐ Yes ☐ No
   For spouse, the person must be named on the application and continually married since date of application. For child, the person must be named on the application if born prior to application. If born after application date, both must meet definition of Covered Person under the policy.

WELL CARE BENEFIT- Please attach a copy of your bill to this form.

For persons NOT residing in California, New York, or Pennsylvania: Fraud Notice:
Any person who knowingly presets 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.

For Residents of California: Fraud Warning 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.

For Residents of New York: Warning 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 fro each such violation.

For Residents of Pennsylvania: Warning: 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 materials thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, or insurance company, to furnish to Humana Insurance Company or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy identified above. I understand that this authorization is valid for two years and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Date_____, 20_____ Signed (patient, or parent if minor)_____

If someone other than the patient executed this form and authorization, indicate reason, give your relationship to patient and address in full:

_____

Relationship to Patient:_____

Address:_____

_____

Mail To:
Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, Texas 78716