Washington National Insurance Company
Home office: 11825 N. Pennsylvania St., Carmel, IN 46032

Questions about your claim submission?
Call (800) 541-2254

CRITICAL CONDITIONS CLAIM FORM

PLEASE SUBMIT THESE ITEMS WITH ALL CLAIMS:

- ☐ Critical claim form (CLM-FORM-CRIT)—signed
- ☐ Authorization to obtain medical/confidential information (see attached form)—signed
- ☐ Itemized medical bills for treatment

Required:

- ☐ Patient information
- ☐ Date of service
- ☐ Charge amount
- ☐ CPT code or procedure description
- ☐ ICD code or diagnosis for treatment

May include:

- ☐ *Surgery* — Operative report and surgeon bill(s) for completed procedures
- ☐ *Hospital and/or emergency room visit* — Admission and/or discharge paperwork and bill(s) for treatment (Examples: UB04, CMS 1500, etc.)
- ☐ Death certificate

WHERE TO SUBMIT CLAIMS:

- ☐ ***Mail:*** Washington National Claims Department, P.O. Box 2024, Carmel, IN 46082-2024
- ☐ ***Express mail:*** Attn: Claim Processing 2024, 11825 N. Pennsylvania St., Carmel, IN 46032
- ☐ ***Fax:*** (888) 229-1414
- ☐ ***Online:*** My.WashingtonNational.com

SECTION A: OWNER INFORMATION (please print)		
Policy or certificate number		
Last name	First name	Middle initial
Date of birth	Social Security number	
Mailing address ☐Check box if this is a new permanent address ☐Check box if address change applies to everyone on the policy		
City	State	ZIP code
If mailing address is a P.O. Box, please indicate physical address here:		
Work address		E-mail
Home phone number	May we leave a voice mail here? ☐Yes ☐No	
Work phone number	May we leave a voice mail here? ☐Yes ☐No	

SECTION B: PATIENT ADDRESS INFORMATION (if different from owner)

Last name	First name	Middle initial
Social Security number	Date of birth	Phone number

SECTION C: PATIENT INFORMATION

Gender:	Marital status:	Relationship:
☐Male	☐Single	☐Self ☐Spouse ☐Dependent
☐Female	☐Married	☐ Check if dependent is a full-time student *(Include documentation to confirm student status)*
	☐Other	☐ Check if dependent is disabled
		☐ Check if insured is deceased; date deceased: ____/____/_____

Please provide the names, addresses and phone numbers of all physicians who have treated you or with whom you have consulted in the last five years:

Name	Address	Phone number

Types of benefits you are claiming (Please reference your policy for available benefits.)

- ☐ Alzheimer's disease
- ☐ Coma
- ☐ Multiple Sclerosis
- ☐ Diabetic amputation
- ☐ End-stage renal failure
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Major organ transplant
  - ☐ *Registered with the organ procurement and transplantation network (OPTN)*
  - ☐ *Underwent transplant surgery*
- ☐Permanent blindness
- ☐Permanent deafness
- ☐Permanent paralysis
- ☐Other _____

Please be sure to include the following information with this claim form:

☐**Itemized bills from a physician and/or facility including diagnosis and/or procedure codes and charge amounts.**
(Itemized bills may include but are not limited to the following claim forms: UB04, CMS 1500, etc.)

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form.

_____ _____ _____/_____/_____
Patient signature (or legal representative) Relationship to owner Date

_____ _____/_____/_____
Owner signature (or legal representative) Date

SECTION D: PHYSICIAN STATEMENT
To be completed and signed by the physician

Please answer each question COMPLETELY. Failure to complete all sections may delay processing of this claim.

Policy or certificate number	Policyholder name
Patient name	Patient date of birth
Physician name	Physician phone number
Physician mailing address	

1. The patient has been diagnosed with _____

2. Date of diagnosis: ____/____/_____ ICD code(s) _____

Please provide a copy of the report that supports the diagnosis of the above. (i.e., pathology, EKG, EEG, CT scan, labs, etc.)

3. Patient first consulted you for this condition on: ____/____/_____

Hospitalization information

Was the patient hospitalized as a result of this diagnosis? ☐Yes ☐No

Was patient confined to an ICU? ☐Yes ☐No

Admission date	Discharge date	Admitting diagnosis/ICD code	Hospital name, city, and state	Was patient transferred to/from hospital?

Surgery/anesthesia information

Did the patient undergo surgery for this condition? ☐Yes ☐No

Where was the surgery per formed? ☐Office ☐Surgical center ☐Hospital

Name of facility:

Date of service	Diagnosis/ICD code	Surgery/CPT code	Description of surgery	Charges

Blood plasma information

Date given	HCPCS/CPT code	Number of units	Charges

_____ _____ _____

Physician signature Date Tax ID number

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