

REQUEST FOR MEDICAL REIMBURSEMENT



ATTN: Medical/Supplement Dept  
AWD BENEFITS DEPARTMENT  
P.O. Box 268898  
Oklahoma City, Oklahoma 73126-8898  
1-800-267-2322 Local 416-7750  
Fax No: 1-888-243-3453

**WARNING: Any person who knowingly, and with intent to and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties. Instructions: 1. Complete statement of Insured. 2. Attach itemized charges with diagnosis. 3. For consideration of ALL hospital charges, itemized bills including diagnosis and medical carriers' Explanation of Benefits must be provided.**

STATEMENT OF INSURED			
<b>A. ABOUT THE PATIENT</b>	<b>PATIENT INFORMATION (CHECK ONE)</b> For whom do you make this request? <input type="checkbox"/> Self <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other <small>identify</small>	Patient's Name _____	Insured's Social Security Number _____
		Patient's Birth Date _____	Patient's Social Security Number _____
		If Claim is for a Dependent Child Under 19, is Such Child Living in Your Household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If Dependent Child is between age 19 and 23 years old, is (s)he a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If student, Name of School _____ Phone Number of School _____	
<b>B. INSURED</b>	Insured's Last Name _____	First Name _____	Initial _____
	Insured's Address (City, State, Zip) _____		Date of Birth _____
	Employer Name _____		Home Telephone Number _____
<b>C. ABOUT THE CLAIM</b>	<b>If Accident</b>	Did the accident result from employment? _____ Yes _____ No	
		If yes, are you filing or will you be filing for Workers' Compensation? _____ Yes _____ No	
		If claim is due to an <b>injury</b> , explain how, where and when it happened. _____ _____	
		_____ _____	
	<b>If Illness</b>	If claim is due to an <b>illness</b> , give date of onset and diagnosis. _____ _____	
		_____ _____	
<b>D. ABOUT THE INFORMATION RELEASE</b>	<b>AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION</b>		
	I hereby authorize the entities specified below to disclose any information about my or my dependents' medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles and k) Workers' Compensation carrier.		
	<b>NOTICE:</b> Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.		
	<i>I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, AWD Benefits Department, P.O. Box 268898, Oklahoma City, Oklahoma 73126-8898 or calling toll free 1-800-267-2322. I understand that my right to revoke this authorization is limited to the extent that AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.</i>		
	<i>I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.</i>		
For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. <b>For Arizona residents</b> , release of HIV/AIDS - released information can only be disclosed for a period not to exceed 180 days from the date shown below.			
Print Insured's/Patient Name _____			
Signature _____		Date: _____	
<i>Please retain a copy for your personal records, or you may request a copy from our company.</i>			