WELLNESS CLAIM FORM

To file your Accident Wellness:
- Print this form and complete highlighted areas
- Scan completed form and documentation of service to your computer
- Return your completed form and documentation of service provided to:
  - Email – alicia@reichardtinsurance.com
  - Fax – 870-698-2933
  - In person – Randy Reichardt Insurance Agency
- Please call Alicia at 870-698-2928 (w) or 870-613-8184 (c) with any questions

POLICYHOLDER

Insured's Name: ______________________ Patient: ______________ ❑ Male ❑ Female

Policy Number(s): 1. ______________________ 2. ______________________

Insured's Social Security Number: ______________________ Patient's Date of Birth: ____/____/____ MO/DAY/YR

Home Number: (______) ______________________ E-mail: ______________________

Filing a claim for your calendar year Wellness Benefit is easy! If you have had one of the listed preventative tests or HPV Vaccination shown below, please check the appropriate boxes and attach any documentation you may have showing the provider, patient's name, the date of the test, and exam performed.

Thank you for selecting ManhattanLife and for having your annual wellness exam!

WELLNESS SCREENINGS	
❑ Annual Physical Exam	❑ Echocardiogram
❑ Biopsy for skin cancer	❑ Flexible sigmoidoscopy
❑ Blood test for triglycerides	❑ Hemocult stool analysis
❑ Bone Marrow Testing	❑ HPV (Human Papillomavirus) Vaccination
❑ CA125 (cancer antigen 125 - blood test for ovarian cancer)	❑ Lipid Panel (total cholesterol count)
❑ CA15-3 (cancer antigen 15-3 - blood test for breast cancer)	❑ Mammography, including Breast Ultrasound
❑ CEA (carcinoembryonic antigen – blood test for colon cancer)	❑ Pap Smear, including ThinPrep Pap Test
❑ Chest X-ray	❑ PSA (prostate specific antigen – blood test for prostate cancer)
❑ Colonoscopy	❑ Serum Protein Electrophoresis (test for myeloma)
❑ Dental Exam	❑ Stress test on bike or treadmill
❑ Doppler screening for carotids	❑ Thermography
❑ Doppler screening for peripheral vascular disease	❑ Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
❑ EKG (Electrocardiogram)	❑ Vision Exam

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to ManhattanLife Assurance Company of America (MAC), its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying MAC in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In MAINE – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: ______________________ Date: ______________ ❑ Check here if address is new
Claimant

Mailing Address: ______________ City: ______________ State: _____ Zip: _______ Phone No: (____) ___________