Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Wellness/Health Screening Claim Form- MA

Claims Customer Service: ☎ Phone: 877-201-9373 **Claims Submission:** **Fax:** 508-471-3208 **or** **Email:** Riderclaims@trustmarkins.com

IMPORTANT NOTICE: In order for us to consider any benefits, you must attach copies of Outpatient Bills / Invoices or Explanation of Benefits to support the testing you had completed. Please complete a SEPARATE FORM FOR EACH CLAIM you are submitting for yourself or for each family member, for each date of service or test. We will only consider one (1) test per claim form. Submission of multiple dates or tests on one claim form will not be considered, except for the most recent date/test.

- ⇨ **Section A & B -** Complete both sections, sign and return to us for consideration of benefits. All questions must be answered in full. **Incomplete or illegible answers may result in delay of benefit consideration**. Please keep a copy of all parts of this form and any attachments for your records.
- ⇨ **Section C –** To be completed if you received your testing through an Employer Sponsored Clinic. Complete Section A & B as well.
- ⇨ **State Required Fraud Language: WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.**

Section A – Policyholder Information *(To Be completed by the Policy Owner)* **Policy #:** ___________ **SSN#**______/____/______

Name: ______________________________________ DOB: ____/____/____ Phone #______________________ ❑Home ❑Cell ❑Work

Address: ____
Street City State Zip Code

Section B – Claimant Information *(To Be completed by the Policy Owner)* Please complete below and attach itemized copies of any related bills to support the testing you or the covered person had completed.

Name of tested person: ____________________________________ DOB: _____/____/____ SSN: ______-______-________

Relationship to Insured: ______________________________________(e.g. spouse, son, daughter)

This is not a guarantee of payment. Benefits will be determined based on your policy provisions and the provisions of your Wellness or Health Screening Rider.

Please note which test you had completed by providing the date it was completed in the section below. As noted above, a separate claim form is needed for each date / test for each person in order for claim to be considered.

TEST OR WELLNESS	Date Completed	TEST OR WELLNESS	Date Completed
Immunization Please indicate for what:	/ /	Serum cholesterol test to determine levels of HDL and LDL	/ /
Routine Physicals	/ /	Bone marrow testing	/ /
Low Dose Mammography INCLUDE COST	/ /	Breast ultrasound	/ /
Pap Smear for women over age 18-COST	/ /	CA 15-3 (blood test for breast cancer)	/ /
Flexible Sigmoidoscopy	/ /	CA125 (blood test for ovarian cancer)	/ /
Hemoccult Stool Specimen	/ /	CEA (blood test for colon cancer)	/ /
Colonoscopy	/ /	Chest X-ray	/ /
Prostate Specific Antigen	/ /	Serum Protein Electrophoresis (blood test for myeloma)	/ /
Stress test on a bicycle or treadmill	/ /	Thermography	/ /
Fasting blood glucose test	/ /		
Blood test for triglycerides	/ /		

Section C: If the above testing was completed as part of a WELLNESS/HEALTH CLINIC sponsored through your employer, Section C below can be completed by the medical professional providing the service in lieu of providing copies of your billing or invoices.

The insured/patient listed below has received the service dated above.

________________________________ Signature of Medical Professional:	________________________________ Print Name:	______/_____/______ Date:
________________________________ Employee Signature:	________________________________ Print Name:	_____/______/______ Date:

DISCLOSURE AUTHORIZATION

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration, or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings, credit history or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS), driving records, credit reports, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Administration to release information or records about me to Trustmark Insurance Company or its authorized representatives. Such release of Social Security information will be used to adjudicate my claim in accordance with my policy benefits, or to continue my eligibility for benefits. I further request that the Social Security Administration release detailed earnings for up to the last ten years and/or a summary record of total earnings and/or information from master benefit records regarding award, denial or continuing Social Security benefits.

I understand that I may revoke this authorization at any time. Any such revocation is to be in writing, signed and dated by me, and must be forwarded directly to Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to me, A photocopy of this Authorization is as valid as the original and I may request a copy. I understand that if I choose I may request a copy of any credit report Trustmark receives in connection with this authorization. This Authorization will be in force for the term of coverage of the policy or up to 12 months from the date shown below, whichever time period is less.

I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Date: ____/____/____ Insured's Signature: ____

Date of Birth: ____/____/____ Relationship, if other than insured: ___________________________________

PLEASE EITHER FAX TO: 508-471-3208 OR SCAN TO: Riderclaims@Trustmarkins.com

Electronic Communication: If you choose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents have access to email communication between you and us.