

CATASTROPHE MAJOR MEDICAL (CMM) CRITICAL ILLNESS CLAIM FORM INSTRUCTIONS

1. When to use this claim form?

This form is to be used for a critical illness claim. The NYSUT Member Benefits CMM Insurance Trust - sponsored CMM plan numbers are CMMI-003 (Voluntary) and CMMI-004 (Group).

2. Who should use this form?

This form is for Voluntary CMM-003 participants with an original critical illness diagnosis date on or after January 1, 2023 and Group CMM-004 participants with an original critical illness diagnosis date on or after January 1, 2018.

3. How do I complete the claim submission?

1. Complete and sign the Participant/Policy Holder & Claimant Information Section;
2. Have your attending physician complete the Attending Physician's Statement section; and
3. Read and sign the HIPAA Authorization form.

4. Do I need to sign the attached HIPAA authorization form?

Yes. By signing this authorization, you will allow HealthSmart Benefit Solutions, the Administrator, to obtain any additional information needed to complete the processing of your claim. Failure to provide the authorization may delay processing.

5. Where should I send the completed claim form?

HealthSmart Benefit Solutions, Inc.
PO Box 1014
Charleston, WV 25324-1014
Fax: 806-473-2535

6. What if I have questions?

Contact HealthSmart Benefit Solutions' customer service team at 844-552-7805 or visit healthsmart.com/nysut.

IMPORTANT

For Group CMM-004 participants, if the original diagnosis occurred prior to January 1, 2018, contact Association Member Benefits Advisors (AMBA) for the appropriate claim form. They can be reached at 888-386-9788, or you can download the form at nysutmbteinsurance.com



PARTICIPANT/POLICY HOLDER & CLAIMANT INFORMATION

Name of Participant (Please Print)		Participant's NYSUT ID #	Policy #(check one) <input type="checkbox"/> CMMI-003 <input type="checkbox"/> CMMI-004	
Participant's Address, Street & No.		City	State	Zip
		Home Phone	Daytime Phone	
Claimant's Name		Claimant's relationship to Participant		
Claimant's Address, Street & No. <input type="checkbox"/> Same as Participant		City	State	Zip
Claimant's Date of Birth	Married <input type="checkbox"/> Single <input type="checkbox"/>	Is Claimant employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
What is the specific Critical Illness for which the claim is being made?	When was the Critical Illness first diagnosed?	Have you ever had the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/>		
List the name, address, and telephone number for all attending physicians for the Critical Illness (Please attach a separate list if additional space is needed).				
If the Critical Illness required hospitalization, provide the name and address of the treating facility (Please attach a separate list if additional space is needed).				

IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with intent to defraud, present or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.

_____ Claimant's signature

_____ Date

Mail or Fax this completed form along with claims and any documentation (if applicable) to:

HealthSmart Benefit Solutions:
PO Box 1014
Charleston, WV 25324-1014
Fax- 806-473-2535

For questions call HealthSmart at:
844-552-7805



ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME		DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? <input type="checkbox"/> YES, WHEN <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)	

CANCER

DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER WAS DIAGNOSED)	WAS THE CANCER/CARCINOMA IN SITU (SELECT ONE). <input type="checkbox"/> PATHOLOGICALLY DIAGNOSED <input type="checkbox"/> CLINICALLY
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IF THE CANCER WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

1. ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS. YES NO
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT. YES NO
3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS. YES NO
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION? YES NO

DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)	DATE:
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CORONARY ARTERY BYPASS SURGERY

DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF YES, ATTACH A COPY OF THE OPERATIVE REPORT.	<input type="checkbox"/> YES <input type="checkbox"/> NO
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WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?
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MAJOR ORGAN TRANSPLANT

DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, KIDNEY, LUNG, LIVER OR BONE MARROW? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	<input type="checkbox"/> YES <input type="checkbox"/> NO
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WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?
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STROKE			
DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTEBROBASILAR ISCHEMIA.			<input type="checkbox"/> YES <input type="checkbox"/> NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.			<input type="checkbox"/> YES <input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES)?			
QUADRIPLEGIA			
DOES THE PATIENT HAVE COMPLETE AND PERMANENT LOSS OF THE USE OF ALL FOUR LIMBS THROUGH PARALYSIS FOR A CONTINUOUS PERIOD OF 180 DAYS OR MORE?			<input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT IS THE CAUSE FOR THE PATIENT'S QUADRIPLEGIA?		WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	
TERMINAL ILLNESS			
DOES THE PATIENT HAVE A MEDICAL CONDITION, WHICH IS EXPECTED TO RESULT IN THE PATIENT'S DEATH WITHIN 12 MONTHS AND FROM WHICH THE PATIENT IS NOT EXPECTED TO RECOVER?			<input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT IS THE CAUSE FOR THE PATIENT'S TERMINAL ILLNESS?		WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	
ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	



**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT ("HIPAA") AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

Claimant's Name	Date of Birth	Participant's NYSUT ID #
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I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Catastrophe Major Medical Insurance Trust ("Trust"), and their authorized representatives, including its administrator, HealthSmart Benefit Solutions, Inc., as well as other agents and insurance support organizations, (collectively, the "Recipients"), the following information:

- Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- Any physician or medical practitioner;
- Any hospital, clinic or other health care facility;
- Any insurance or reinsurance company;
- Any consumer reporting agency or insurance support organization;
- My employer, group policy holder, or benefit plan administrator; and
- The Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipients to:

- Determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- Detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust's HIPAA Privacy Notice, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: HealthSmart Benefit Solutions, Inc., PO Box 1014, Charleston, WV 25324-1014. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipients may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Claimant or Claimant's Personal Representative

Date

Description of Authority of Personal Representative (if applicable)