MetLife

Group Critical Illness Insurance Claim Form - Physician Statement

Metropolitan Life Insurance Company

Patient or authorized representative must sign Section 1 below.
The Physician/Provider must complete and sign Section 2.

Important Instructions for Requesting Critical Illness Benefits

- The patient submitting a Critical Illness claim must complete Section 1 before giving it to their physician.
- Any fee charged by the physician for completing this form is the patient's responsibility.
- The physician must complete and sign Section 2.
- Please include with this form any relevant medical documentation that specifically provides information regarding diagnosis and treatment plan/prognosis.
- The physician or claimant may return the completed claim form and any attachments by fax or by mail to the address listed on this form.
- Examples of medical documentation and information needed based on the patient's condition:

If your claim is for any of these conditions	**Please include the following medical information with your claim**
Full Cancer	Pathology Reports, Surgical Reports, TNM Stage Classification
Partial Cancer	Pathology Reports, Surgical Reports, TNM Stage Classification
All Cancer Types	Office notes/medical records that show observation of signs, symptoms and tests that confirm the diagnosis
Coronary Artery Bypass Surgery	Open heart surgical reports and documentation showing diagnostic need for surgery
End Stage Kidney Failure	Kidney Specialist records or dialysis records
Heart Attack	Hospital Summary, EKGs, Cardiac Enzymes. If completed, provide any of the following: Thallium Scans, Muga Scans, Stress echocardiogram, Cardiac Catheterization Report
Bone Marrow, Heart Transplant or Major Organ Transplant	Surgical Report and Clinical Records
Stroke	Documented Neurological deficits, Neuroimaging studies, Clinical Records and Documentation of deficits 30 days post event
Listed Conditions	Specialist records, Lab results, Records showing observation of signs, symptoms and tests that led to the Diagnosis of the Listed condition

SECTION 1: Patient authorization & signature

I authorize the release of any medical information necessary to process this claim.

Sign Here	Signed	Date *(mm/dd/yyyy)*
Relationship to insured		

SECTION 2: Information needed from your Physician/Provider

► 2A - Patient information

First name	Middle	Last name

Address	City	State	ZIP

Date of birth *(mm/dd/yyyy)*	Gender	Daytime phone number

► 2B - Condition information

Please advise us of the condition for which your patient was diagnosed and/or treated for

ICD 10 Code _____ CPT Code _____

If the claimant is deceased, check here ☐

Date of Diagnosis *(mm/dd/yyyy)* *First symptom(s)/Diagnosis date*	Date your patient first consulted you for this condition *(mm/dd/yyyy)*

Has the patient previously been treated with the same or similar condition? ☐ Yes ☐ No

If "yes," indicate first treatment date and details.

► 2C - Referring and other treating physicians for this illness *(if applicable)*

First name	Middle name	Last name

Address	City	State	ZIP

Phone	Fax

First name	Middle name	Last name

Address	City	State	ZIP

Phone	Fax

For services related to hospitalization, provide hospitalization dates.

Date confirmed *(mm/dd/yyyy)*	Through *(mm/dd/yyyy)*	Hospital name

Address	City	State	ZIP

Please include all pertinent medical information related to this claim(s). Please refer to the "**Important Instructions**" section of this form for examples of medical information and documentation necessary to review this claim.

► 2D - Medical provider signature and medical specialty

First name	Middle	Last name

Address	City	State	ZIP

Phone	Fax

Medical specialty

Sign Here Signature | Date *(mm/dd/yyyy)*

SECTION 3: How to submit this form

Mail:
Attn: Critical Illness Insurance Product
P.O. Box 6120
Scranton, PA 18505-9972

We're here to help

Please don't hesitate to contact us if you have any questions. You can reach us toll free at 1-800-438-6388, fax 1-866-268-2621 and email CITampa@metlife.com.