HEART SCREENING CLAIM FORM

Claimants Age 18+ Only

Claim Information

Policyholder Name: ______________________________ Heart/Stroke Policy Number: ____________________

Policyholder Address: ____
Street City State Zip

Claimant Name: ________________________________ Claimant Date of Birth: _________________________
MM/DD/YYYY

Important: Please complete one form per date of service and select each type of service performed on that date. Fill in provider name, telephone number, and date of service. Failure to complete all sections may result in a delay in processing this claim.

Note: *Heart screenings can only be considered for benefits if you have a heart attack and stroke insurance policy.*

Heart and Circulatory Screenings:

☐ Angiogram
☐ Blood test to confirm elevated cardiac enzymes
☐ Cardiac C-Reactive Protein (CRP)
☐ Carotid Ultrasound
☐ Cholesterol/ Lipid Panel/ Triglycerides
☐ CT Scan of the heart for calcium scoring
☐ Echocardiogram
☐ Electrocardiogram
☐ Heart Catheterization
☐ Stress Test on a bicycle or treadmill
☐ Thallium Scan

Date of Service: ________________________________
MM/DD/YYYY

Provider Name: ________________________________ Provider Telephone: (_______) _____________

DO NOT INCLUDE – Receipts, Statements, Test Results, Itemized Bills, or Other Claim Forms

Acknowledgement

All benefits of this Rider are per Covered Person and are subject to the terms, definitions, provisions, limitations, and exclusions of the policy to which it is attached. Any person who knowingly files a statement of claim containing false, incomplete or misleading information may be subject to civil and criminal penalties. The Provider listed above is authorized to validate the information I have provided.

Signature: ______________________________ Date: ____________________________
MM/DD/YYYY