MetLife

Critical Illness Insurance Claim - Physician Statement

Things to know before you begin

- The patient submitting this Critical Illness Claim must complete Section 7 before giving it to a physician.
- Any fee charged by the physician for completing this form is the patient's responsibility.
- The physician must sign section 8E after completing the claim form.
- The physician must return the completed claim form and any attachments by fax or by mail to the address listed in the header of the claim form or directly to the patient.
- If you have questions, please call 1 866 626 3705.

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826
Toll Free Phone: 1 866 626 3705
Fax Number: 1 855 306 7350
https://mybenefits.metlife.com

You must sign Section 7 below. Your Physician/Provider must complete Section 8.

SECTION 7 - Patient Authorization & Signature

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

Signed	**Date** *(mm/dd/yyyy)*

Relationship to Insured

SECTION 8 - Information Needed From Your Physician/Provider

8A - Patient Information

First Name	Middle Name	Last Name

Street Address

City	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	Gender	Daytime Phone Number

8B - Condition Information

Check off the condition with which your patient was diagnosed / treated for:

☐ Cancer
☐ Coronary Artery Bypass Graft
☐ Heart Attack
☐ Stroke
☐ Alzheimer's Disease
☐ Kidney Failure
☐ Major Organ Transplant

If the claimant is deceased, check here ☐

Listed Conditions *(check the Listed Condition(s) being claimed)*:

☐ Addison's disease *(adrenal hypofunction)*
☐ Amyotrophic lateral sclerosis *(Lou Gehrig's disease)*
☐ Cerebral palsy
☐ Cerebrospinal meningitis *(bacterial)*
☐ Cystic fibrosis
☐ Diphtheria
☐ Encephalitis
☐ Huntington's disease *(Huntington's chorea)*
☐ Legionnaire's disease
☐ Malaria
☐ Multiple sclerosis *(definitive diagnosis)*
☐ Muscular dystrophy
☐ Myasthenia gravis
☐ Necrotizing fasciitis
☐ Osteomyelitis
☐ Poliomyelitis
☐ Rabies
☐ Sickle cell anemia *(excluding sickle cell trait)*
☐ Systemic lupus erythematosus *(SLE)*
☐ Systemic sclerosis *(scleroderma)*
☐ Tetanus
☐ Tuberculosis

Date of Illness *(mm/dd/yyyy)* *(First Symptom/Diagnosis Date)*	Date your patient first consulted you for this condition *(mm/dd/yyyy)*

Has the patient previously had the same or similar condition? ☐ Yes ☐ No If "yes," indicate first treatment dates.

8C - Referring and Other Treating Physicians

First Name	Middle Name	Last Name	
Street Address		Phone Number	
City		State	ZIP Code

First Name	Middle Name	Last Name	
Street Address		Phone Number	
City		State	ZIP Code

For services related to hospitalization, give hospitalization dates.

Date Confined *(mm/dd/yyyy)*	Through *(mm/dd/yyyy)*	Hospital Name	
Street Address			
City		State	ZIP Code

Date Confined *(mm/dd/yyyy)*	Through *(mm/dd/yyyy)*	Hospital Name	
Street Address			
City		State	ZIP Code

8D - Please provide the relevant medical documentation as noted below.

History and Medical Documentation needed based on condition checked:

- Full Benefit Cancer – Pathology Reports, surgical reports and TNM Stage ______________
- Partial Benefit Cancer – Pathology Reports, surgical reports and TNM Stage ____________
- Coronary Artery Bypass Surgery – Open heart surgical reports
- End Stage Kidney Failure – Kidney Specialist records or dialysis records
- Heart Attack – All of the following: Hospital Summary, EKGs, Cardiac Enzymes. If completed, provide any of the following: Thallium Scans, Muga Scans, Stress echocardiogram, Cardiac Catheterization Report
- Bone Marrow, Heart 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.

8E - Medical Provider Signature and Medical Specialty

Please Print Your Name		Phone Number
Signed		Date *(mm/dd/yyyy)*
Street Address	Medical Specialty	
City	State	ZIP Code