

# Group Critical Illness and Cancer 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 and/or Cancer Benefits

- The patient submitting a Critical Illness or Cancer 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, email, or by mail to the address listed on this form.  
Claimants may also submit this completed form at <https://mybenefits.metlife.com>.
- 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 \_\_\_\_\_

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**SECTION 2: Information needed from your Physician/Provider****► 2A - Patient information**

|                                     |             |                      |       |     |
|-------------------------------------|-------------|----------------------|-------|-----|
| First name                          | Middle name | Last name            |       |     |
| Address                             |             | City                 | State | ZIP |
| Date of birth ( <i>mm/dd/yyyy</i> ) | 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 |
| First name | Middle name | Last name |       |     |
| Address    |             | City      | State | ZIP |

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 name | Last name | Phone number |
|------------|-------------|-----------|--------------|

|         |      |       |     |
|---------|------|-------|-----|
| Address | City | State | ZIP |
|---------|------|-------|-----|

Medical Specialty

|                  |           |                            |
|------------------|-----------|----------------------------|
| <b>Sign Here</b> | Signature | Date ( <i>mm/dd/yyyy</i> ) |
|------------------|-----------|----------------------------|

**How to submit this form**

**Mail:**  
Attn: Cancer/Critical Illness Insurance Products  
P.O. Box 80826  
Lincoln, NE 68501-0826

**We're here to help**  
Please don't hesitate to contact us if you have any questions. You can reach us toll free at 1-866-626-3705, fax 1-855-306-7350 and email [ahmetlifeclaims@metlife.com](mailto:ahmetlifeclaims@metlife.com).