CANOPY INSURANCE
ROOTED IN ALABAMA

Mail to: Canopy Insurance Claims Processing, PO Box 3187, Tuscaloosa, AL 35403
Email to: Claims@CanopyInsuranceCorp.com
Fax to: 205-409-2527

Accident Wellness Benefit Claim Form

Please submit this form via mail, email, or fax. Be sure to include any additional pages used to respond to the questions below along with any documentation from your healthcare provider to support this claim. If you have any questions , please call our **Customer Service Department at 205-451-0444**.
Note: Some of the services listed may not be covered by your policy. Refer to your certificate of coverage for benefits available under your plan.

GROUP INFORMATION

Group Name: _____ **Group Number:** _____

Group Contact Information (This is generally someone in Human Resources or Administration)

Contact Name: _____ **Email:** _____ **Phone Number:** _____

PRIMARY INSURED INFORMATION

Full Name: _____ **DOB:** _____ **SSN:** _____ **Member ID:** _____

Mailing Address: _____
Street *City* *State* *Zip*

Phone Number: _____ **Email:** _____

CLAIMANT INFORMATION

Full Name: _____ **DOB:** _____ **Gender:** _____ **Relationship:**

Phone Number: _____ **Email:** _____ **Date of Death (if applicable):** _____

CLAIM INFORMATION

PLEASE CHECK WELLNESS EXAM BOXES FOR TEST(S) AND/OR TREATMENT(S) FOR WHICH YOU ARE CLAIMING A BENEFIT.
Attach medical documentation that indicates the type of test performed and the date test was performed.

- ☐ Biopsy for Skin Cancer
- ☐ Blood Test for Triglycerides
- ☐ Bone Marrow Testing
- ☐ Breast Ultrasound
- ☐ CA15-3 (Blood Test for Breast Cancer)
- ☐ CA125 (Blood Test for Ovarian Cancer)
- ☐ CEA (Blood Test for Colon Cancer)
- ☐ Chest X-Ray
- ☐ Colonoscopy
- ☐ Doppler Screening for Carotids
- ☐ Doppler Screening for Peripheral Vascular
- ☐ Disease Echocardiogram
- ☐ EKG (Electrocardiogram)
- ☐ Flexible Signoidoscopy
- ☐ Hemocult Stool Analysis
- ☐ HPV Vaccination
- ☐ Lipid Panel (Total Cholesterol Count)
- ☐ Mammography
- ☐ Pap Test
- ☐ PSA (Blood Test for Prostate Cancer)
- ☐ Serum Protein Electophoresis
- ☐ Stress Test on Bike/Treadmill
- ☐ Thermography
- ☐ Ultrasound of Abdominal Aorta for Aneurysm
- ☐ Other Cancer Screening Not Listed (explain): _____

Date Test Performed: _____

PROVIDER INFORMATION

Practice Name: _____ **Provider Name:** _____

Address: _____
Street *City* *State* *Zip*

Phone Number: _____ **Fax:** _____

AUTHORIZATION

I authorize any third party to release any and all medical and non-medical information about me to Canopy Insurance Corporation or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that information obtained by this authorization is to determine eligibility for insurance or eligibility for benefits under an existing plan. Canopy will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I may request and receive a copy of this authorization, and agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

_____ _____
Signature of Primary Insured or Power of Attorney (attach Power of Attorney, if applicable) Date

_____ _____
Signature of Claimant (if different than Primary Insured) or Power of Attorney (attach Power of Attorney, if applicable) Date