ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM
CANCER INSURANCE PROGRAM

CLAIM FORM

PO BOX 17323 PHOENIX, AZ 85001-11323 TEL (602)255-5575 FAX (602)296-2371

Name of Member/Claimant	Social Security Number	Sex ☐ Male ☐ Female	☐ Single ☐ Married ☐ _________	Date of Birth

Address	City	State	Zip	Telephone

Name of illness	Date illness first diagnosed	Department name

Have you Claimed Benefits for this condition Previously? ☐ **Yes** ☐ **No** **If Yes, when**

Name and Address Of Physicians Who Were Consulted For This Condition

Name	Address	
Name	**Address**	**Phone**
Name	**Address**	**Phone**

Warning and Notice: Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines and/or imprisonment.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly prevents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines or confinement in state prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Authorization: I authorize my doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient, employee or deceased, including financial institutions, to give Public Safety Personnel Retirement System or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs. A photocopy of this form is as valid as the original. This form will be in force for one year from the date shown below. I may revoke it at any time for information not then obtained by writing to Public Safety Personnel Retirement System. I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.

Signature of Member	Date

FILE A CLAIM

Attach Pathology report confirming diagnosis, hospital bills, physicians bills, billing statements, explanation of benefits (EOB) and any other related expenses and send to: PSPRS ó CANCER INSURANCE PROGRAM Attn: Claims Representative PO BOX 17323 Phoenix, AZ 85011-1323
TEL (602) 255-5575 FAX (602) 296-2371

ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

Cancer Insurance Program PO BOX 17323 PHOENIX, AZ 85001-11323 TEL (602)255-5575 FAX (602)296-2371

Attending Physician Statement
(Completed by Physician)

Patient Name: ______________________ SSN:_______________

1. Date of First Symptoms	2. Date First Consulted for this Condition	3. Date Condition First Diagnosed
________________________	________________________	________________________

4. Has patient ever been previously treated for this condition or related conditions?
☐ YES ☐ NO If yes, give date and diagnosis of prior advice and treatment

5. Name and address of physician who referred this patient

6. Name and address of hospital where services rendered

7. Name and address of treatment facility where services rendered

8. For services performed in hospital	Date of First Symptoms	Date Discharged	9. For services performed in Treatment Facility	Date Admitted	Date Discharged
	_________	_________		_________	_________

10. Inclusive Dates Patient was confined in an Intensive Care Unit of Hospital

___________________ to ___________________

11. Please Provide Names and Addresses of other Physicians currently treating patient

12. Diagnosis of illness or injury requiring services
(relate Diagnosis to procedure by reference to numbers 1,2,3, etc. In col. D
1)
2)
3)

13. A	B	C		D	E
Date of each service	Place of Service * see code below	Describe the medical procedures and other services for each date Procedure Code	(Explain unusual circumstances)	DX No.	Charges
					Total Charges

Date **Physicians Name (print)** **Signature**

Address **City** **State** **Zip**

______ - ______ - _______ **Individual Practitioners SSN**	______ - _____________ **Employer Tax ID #**

* Place of Service Codes

1-(IH) Inpatient Hospital	4-(H) Patient's Home	7-(NH) Nursing Home	O-(OL) Other Locations
2-(OH) Outpatient Hospital	5-psychiatric day care facility	8-(SNF) Skilled nursing home	A-(IL) independent lab
3-(O) Doctors Office	6-psychiactric night care facility	9-Ambulance	B-(ASC) Ambulatory Surgical Center