Mailing Address:
P.O. Box 1250
Tuscaloosa, Alabama 35403

Southland
BENEFIT SOLUTIONS

EMPLOYEE'S STATEMENT

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

1. SUBSCRIBER'S NAME		2. SUBSCRIBER'S CONTRACT NUMBER	
3. HOME ADDRESS: street, city, state and zip code			
4. PATIENT'S NAME	5. DATE OF BIRTH	6. AGE	7. SEX M ☐ F ☐
8. PATIENT'S RELATIONSHIP TO SUBSCRIBER self ☐ spouse ☐ child ☐	9. SUBSCRIBER'S TELEPHONE home: work:		
10. TYPE OF ILLNESS/INJURY, OR DOCTOR'S DIAGNOSIS:			
PHYSICIAN'S NAME AND ADDRESS			
NAME OF HOSPITAL, IF CONFINED	DATE ADMITTED	DATE DISCHARGED	
DATE ACCIDENT OR SICKNESS BEGAN month day year	WAS CONDITION RELATED TO: ACCIDENT_____		
DATE FIRST TREATED month day year	ILLNESS_____		

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to give Southland National Insurance Corporation or Benefit Administrators any additional information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Date:_____ Subscriber's Signature: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐ ILLNESS? YES ☐ NO ☐ ACCIDENT? YES ☐ NO ☐

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)
(IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATES OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED

4. DATE PATIENT CONSULTED YOU FOR THIS CONDITION	5. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐
PHYSICIAN'S NPI #	PHYSICIAN'S T.I.N. or SSN #

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

HOW TO FILE A CLAIM

TO ASSURE PROMPT AND ACCURATE HANDLING OF YOUR CLAIMS, FOLLOW THESE 5 SIMPLE STEPS:

STEP 1

Complete this form as soon as possible.

STEP 2

Fill in every question completely and accurately.

STEP 3

Ask doctor to complete Physician's Statement and return to you.

STEP 4

Attach itemized copy of hospital bill.

STEP 5

Mail this form with a copy of your hospital bill to:

Southland Benefits Administration
P.O. Box 1250
Tuscaloosa, Alabama 35403

NOTE:

PLAN DOES NOT COVER OUTPATIENT TREATMENT FOR ILLNESS.