STATEMENT FOR PRIVATE NURSING EXPENSES

Any person who knowingly and with intent lo defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information or suppression or concealing any material information is guilty of a crime.

LIBERTY NATIONAL LIFE INSURANCE COMPANY
P.O. BOX 8080
MCKINNEY, TX 75070

NURSE AND LICENSE INFORMATION

PLEASE PRINT

Name of Nurse: _____
(Last) (First) (Middle)

Address: _____
(Street and No.)

_____
(City) (State) (ZIP Code)

Area Code and Telephone Number (_____) _____

Are you member of the patient's family? ❑ Yes ❑ No

Must be licensed to practice as a L.P.N. or R.N. in the state where the service is rendered.

Certificate Number: _____

Renewal Number: _____ Expires: _____

SERVICES RENDERED

TO BE COMPLETED BY NURSE

DATE	SHIFT OR HOURS WORKED	CHARGED
		TOTAL CHARGE $

PATIENT AND POLICY INFORMATION

PLEASE PRINT

Name of Patient: _____
(Last) (First) (Middle)

Address: _____
(Street and No.)

_____
(City) (State) (ZIP Code)

Liberty National Policy No. _____

NURSE'S CERTIFICATION

I hereby certify that the foregoing statements are true and complete to the best of my knowledge.

Signature of Nurse, R.N. or L.P.N _____

Date Signed _____

DOCTOR'S CERTIFICATION

The patient referenced is currently under my care and required the attendance of this Private Duty Nurse for the treatment of cancer for service dates above.

Signature of Treating Physician _____

Print Name of Treating Physician here _____

Date signed _____

PATIENT'S SIGNATURE

Signature of Patient _____ Date Signed _____

R-1748, Ed. 5-97

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TRANSPORTATION STATEMENT

Patient _____ Policy Number _____

Insured _____

INSTRUCTIONS

This statement should be completed to request reimbursement of charges for medically necessary transportation for the treatment of cancer (maximum of six trips in a 12-month period).

For transportation to be payable Liberty National must receive the following:

1. A copy of the bill or ticket of such transportation charges must be attached to this statement. If by personal automobile, list round trip mileage in space provided below:

NAME OF FACILITY	DATE TRANSPORTED		MODE OF TRAVEL (Air, Taxi, Personal Auto, Etc.)	If travel was by personal auto, list round trip mileage.
	TO:	FROM:		
Example: John Doe Hospital	3/1/95	3/14/95	Personal Auto	550 miles
1.				
2.				
3.				
4.				
5.				
6.				

2. The provider's original bill (or copy) including diagnosis, as well as the provider's signature If by personal automobile, list round trip mileage in space provided below:

I certify that the above is true and accurate:

_____ _____ _____
Signature of Insured Print Name of Insured Date