TRANSAMERICA
WORKSITE MARKETING

Transamerica Life Insurance Company
Administrative Office: P.O. Box 8043
Little Rock, AR 72203-8043
Phone: 1-800-251-7254 (7:00 A.M. – 5:00 P.M. CST)
Fax: 866-586-6528 Email: shtwmclaimsscanning@aegonusa.com

TransConnect® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of it's rights or defenses

To file a claim: Complete Sections 1 and 2. Attach an itemized statement or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized statement attached (if applicable) to the address above with an Explanation of Benefits (EOB) from your primary medical carrier for these specific expenses.

SECTION 1 – EMPLOYEE INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Certificate Number/SSN
4. Address (*include city, state and zip code)*		5. Phone Number

SECTION 2 – PATIENT'S INFORMATION – Please attach an itemized statement: CMS1500 or UB92.

1. Patient's Full Name	2. Date of Birth	3. Relationship to Employee: ❒Self ❒Spouse ❒Child ❒Stepchild ❒Other

4. Gender ❒ Male ❒ Female	5. Social Security Number	6. Date of Accident (If applicable)	7. If auto accident, was patient: ❒ Driver ❒ Passenger ❒ Unknown

8. Worker's Compensation ❒ Yes ☑ No	9. Date of Service	10. Place of Service (Example: Doctor's Office, Hospital, ER, etc.)	11. Description of Services Performed (Example: x-ray, lab test, etc.)
12. Reason for Visit (Example: Broken Arm, Flu, etc.)	13. Pay Provider ❒ Yes ☑ No	14. Provider's Name and Address	

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT – To be completed by physician only if no itemized statement. EDI Payer 59222

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Transamerica Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

Signature of Patient (If minor, parent/guardian must sign) _____ Date _____

If signed on behalf of another, indicate your relationship (Only if patient is unable to sign) _____

(Expires six months from this date unless indicated or revoked earlier.)

1. Name and Address of Facility where Services Rendered

2. Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by Reference to Number 1, 2, 3, Etc. or DX Code

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given: Procedure Code (Identify)	Explain Unusual Services or Circumstances	D Diagnosis Code	E Charges	F

Your Patient's Account Number	Total Charge	Amount Paid	Balance Due

Physician's Name (please print)	Signature	Date	Tax ID Number or SSN

Street Address	City	State	Zip	Phone Number