MEDICO®
INSURANCE COMPANY
Corporate Office - Omaha, Nebraska
Administrative Services - P.O. Box 10386, Des Moines, Iowa 50306-0386

Medico® Claim Form

What to Know About Filing Your Claim

You can avoid unnecessary processing delays by making sure you provide all of the following:

1. A claim form, with the Patient's Statement completed by the patient about the claim and the Physician's Statement completed and signed by the physician.
2. The HIPAA Authorization needs to be signed and dated so we can contact your medical provider on your behalf if additional information is needed.
3. Any itemized provider bills (a balance due statement from the provider is not enough).
4. On a Hospital Bill make sure the statement indicates:
   a. Date of Admission
   b. Date Discharged
   c. The number of Room and Board days being charged
   d. If observation hours are being charged, we will need to see the number of hours/units spent
   e. Diagnosis Codes
5. If filing with a Cancer diagnosis, please include the pathology report.

Return the completed form, the signed and dated HIPAA Authorization and any itemized bills to:

Medico Insurance Company
P. O. Box 21660
Eagan, Minnesota 55121-0660

Fax: 1-402-496-8199

Note: Your Policy has a 6 Month Pre-Existing Conditions Limitation and a 2 Year Policy Contestability Period. A claim happening during the first two years may require additional information. If we need to request additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.

If you have an assignment of benefits on file with the provider and you have a balance still due, we will have to pay benefits directly to the provider; otherwise benefits will be sent to you.

We suggest you make photocopies of any correspondence sent to our office to keep for your records.

If you have any questions,
please contact our Claims Department.

1-800-228-6080

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Patient's Statement

PLEASE NOTE: IT IS IMPORTANT THAT ALL QUESTIONS BE ANSWERED IN FULL AND THAT THIS FORM BE RETURNED TO THE COMPANY. IF PATIENT IS A MINOR, QUESTIONS SHOULD BE COMPLETED BY THE INSURED. IF CLAIM IS FOR HOSPITAL OR PHYSICIAN EXPENSES PLEASE ATTACH ITEMIZED BILLS.

1. Insured's Name _____

2. Policy Number _____

3. Address _____
Street City State ZIP

   a. If new address, please check box ❑

4. Phone Number (_____) _____-_____

5. Patient's Name (if other than Insured) _____

6. Patient's Date of Birth _____ / _____ / _____

7. Date Patient became ill with this condition _____ / _____ / _____

8. Please list condition _____

9. Date Patient first saw any Physician for this condition _____ / _____ / _____

10. Name and address of Physicians who treated you for this condition.

_____

_____

_____

11. Were you ever sick with this condition before? ❑ Yes ❑ No a. If yes, when _____ / _____ / _____

12. Family Physician's Name _____

13. Family Physician's Address _____
Street City State ZIP

14. Hospital Name _____

15. Hospital Address _____
Street City State ZIP

I understand that this information will be used by Medico Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Be sure to sign below AND the attached authorization

Name of Patient	**Signature of Patient, Authorized Representative, or Next of Kin**	**Date Signed (Month Day Year)**

(If Patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. IF PATIENT IS DECEASED, Personal Representative or Next of Kin must sign.) **The Furnishings of the Form is not admission of any Liability on the part of the Company.**

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Physician's Statement

PATIENT'S & INSURED INFORMATION

1. PATIENT'S NAME (First Name, Middle Int. Last Name)		2. PATIENT'S DATE OF BIRTH
3. PATIENT'S ADDRESS (Street, City, State, ZIP)		4. TELEPHONE NO. ( )
5. PATIENT'S SEX MALE ❑ FEMALE ❑	6. PATIENT'S RELATIONSHIP TO INSURED SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑	7. INSURED'S POLICY NUMBER
8. INSURED'S NAME (First Name, Middle Int. Last Name)		9. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ❑ NO ❑ B. AN AUTO ACCIDENT YES ❑ NO ❑
10. INSURED'S ADDRESS (Street, City, State, ZIP)		
11. ASSIGNMENT I authorize payment of medical benefits to undersigned physician or supplier for service described below. **SIGNED** (Insured or Authorized Person)		

PHYSICIAN OR SUPPLIER INFORMATION

12. DATE OF ILLNESS (FIRST SYMPTOM OR INJURY (ACCIDENT OR PREGNANCY)	13. DATE FIRST CONSULTED YOU FOR THIS CONDITION	14. HAS PATIENT HAD SAME OR SIMILAR SYMPTOMS? YES ❑ NO ❑
15. IS THIS INJURY OR SICKNESS WORK RELATED? YES ❑ NO ❑	16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
17. FOR HOSPITALIZATION, LIST DATES: ADMITTED DISCHARGED		
18. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 1. _____ 3. _____ 2. _____ 4. _____		

20. A. DATE OF SERVICE From: mm/dd/yyyy To: mm/dd/yyyy	B. PLACE OF SERVICE	C. CPT/HCPCS	D. MODIFIERS	E. DIAGNOSIS POINTER	F. CHARGES		G. DAYS OR UNITS
					21.TOTAL CHARGES		

22. SIGNATURE OF PHYSICIAN OR SUPPLIER **SIGNED** **DATE**		
23. FEDERAL TAX I.D. NUMBER SSN# ❑ EIN# ❑	24. PATIENT'S ACCOUNT NO.	25. AMOUNT PAID
26. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP, & TELEPHONE #.		

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For your protection state law requires the following statements to appear on this form.	
FRAUD WARNING STATEMENT	
Alabama	Any person who knowingly presents 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.
California	For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
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 within the department of regulatory agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the ***purpose of defrauding*** the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."
New York	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 concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
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 concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Rhode Island	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Residents of All Other States	**WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**
The furnishing of forms does not constitute an admission of liability on the part of the Company.	

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Authorization for the Use and Disclosure of Information

I hereby authorize Medico® Insurance Company to use and/or disclose the following information about me as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations**.

Policy Number: _____ ____ /____ /____
Date of Birth

_____
Full name of insured whose information is being requested for use/disclosure

1. Persons/class of persons authorized to use or make disclosure of the information: ***Any health care providers from whom you sought treatment or received consultation.***

2. Name and address of persons/class of persons authorized to receive the information: ***Medico Insurance Company staff with appropriate access clearance to use and disclose the applicable information.***

3. Specific description of information that may be used/disclosed:
   - ☐ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
   - ☐ **Other**, please specify: _____

4. The information will be used/disclosed for the following purposes (*all* purposes must be listed and described):
   - ☐ **Benefit/Payment Purposes** (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, explanation of benefits, assessment of coverage needs)
   - ☐ **Other**, please specify: _____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, Medico Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that Medico Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.

(Continued)

6. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. Medico Insurance Company or another third party has taken action in reliance on this authorization; or
   b. this authorization is obtained as a condition for obtaining insurance coverage, other law may provide Medico Insurance Company with the right to contest a claim under the policy or the policy itself.

   I understand to revoke my authorization I should send my written revocation request to:

Medico Insurance Company
P. O. Box 21660
Eagan, Minnesota 55121-0660
Fax: 1-402-496-8199

7. This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

If you are signing as a personal representative for the policyholder, please read and sign below.

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____, that my relationship to the policyholder is _____, and that I have the lawful authority to enter into this authorization on behalf of the policyholder. I have read the provisions set forth in this authorization, and agree that Medico Insurance Company may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____
Signature of Individual or Personal Representative *Date*

_____ _____
Printed Name of Individual or Personal Representative *Relationship of Personal Representative or Authority to Act for the Individual*

You will be provided a copy of this signed Authorization.