MEDICO®
INSURANCE COMPANY

*Corporate Office – Omaha, NE*
*Administrative Services – P.O. Box 10386*
*Des Moines, IA 50306*
*www.gomedico.com*
*Toll-Free 1-800-228-6080*

Dear Insured:

Please use the attached claim form to file your dental claim. We have outlined the steps that you should take once you have reviewed the claim form. It is important that you complete all applicable information in full to ensure prompt claim processing.

**How to Submit Your Claim:**
Locate your policy number on your ID card and follow the guidelines below.

**If the first 3 digits of your policy number begin with "774", please submit your claim form as follows:**

| |
|---|
| You may fax your claim form to:<br>Claims Fax: 1-717-481-8215 |
| You may mail your claim form to:<br>Medico Insurance Company Claims<br>PO BOX 10188<br>Lancaster, PA 17605 |
| For questions, please call our Customer Service Center at 1-855-363-8863.<br>Representatives are available Monday through Friday,<br>from 7:30 a.m. to 4:45 p.m., Central time. |

**For all other policy numbers, please submit your claim form as follows:**

| |
|---|
| You may fax your claim form to:<br>Claims Fax: 1-402-938-9459 |
| You may mail your claim form to:<br>Medico Insurance Company Claims<br>Administrative Services<br>PO BOX 10386<br>Des Moines, IA 50306 |
| For questions, please call our Customer Service Center at 1-800-228-6080.<br>Representatives are available Monday through Friday,<br>from 7:30 a.m. to 4:45 p.m., Central time. |

You are a valued policyholder. We thank you for choosing Medico Insurance Company.

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DENTAL INSURANCE CLAIM FORM

# DENTAL CLAIM FORM

## HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   - ❒ Statement of Actual Services
   - ❒ Request for Predetermination/Preauthorization
   - ❒ EPSDT/Title XIX
2. Predetermination/Preauthorization Number _____

## PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

## OTHER COVERAGE

4. Other Dental or Medical Coverage?
   ❒ No (Skip 5-11) ❒ Yes (Complete 5-11)
5. Other Insured's Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) _____
7. Gender ❒ M ❒ F
8. Subscriber Identifier (SSN or ID#) _____
9. Plan/Group Number _____
10. Patient's Relationship to Other Insured (Check applicable box)
    ❒ Self ❒ Spouse ❒ Dependent ❒ Other
11. Other Carrier Name, Address, City, State, Zip Code

## PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) _____
14. Gender ❒ M ❒ F
15. Subscriber Identifier (SSN or ID#) _____
16. Plan/Group Number _____
17. Employer Name _____

## PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box)
    ❒ Self ❒ Spouse ❒ Dependent Child ❒ Other
19. Student Status ❒ FTS ❒ PTS
20. Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) _____
22. Gender ❒ M ❒ F
23. Patient ID/Account # (Assigned by Dentist) _____

## RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)

| Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | | 32. Other Fee(s) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J | | | | |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K | 33. Total Fee | | | |

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____

Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____

Subscriber signature Date

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

_____

_____

49. Provider ID _____

50. License Number _____

51. SSN or TIN _____

52. Phone Number (_____) _____

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
❒ Provider's Office ❒ Hospital ❒ ECF ❒ Other

39. Number of Enclosures (00 to 99) Radiograph(s) ____ Oral Image(s) _____ Model(s) _____

40. Is Treatment for Orthodontics? ❒ No (Skip 41-42)
❒ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) _____

42. Months of Treatment Remaining _____

43. Replacement of Prosthesis? ❒ No ❒ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY) _____

45. Treatment Resulting from (Check applicable box)
❒ Occupational illness/injury ❒ Auto accident
❒ Other accident

46. Date of Accident (MM/DD/CCYY) _____

47. Auto Accident State _____

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____

Signed (Treating Dentist) Date

54. Provider ID _____

55. License Number _____

56. Address, City, State, Zip Code

_____

_____

57. Phone Number (_____) _____

58. Treating Provider Specialty _____

**Attention Residents of ALABAMA:** Any person who knowingly presents a 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.

**Attention Residents of ALASKA:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Attention Residents of ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Attention Residents of ARKANSAS, LOUISIANA and WEST VIRGINIA:** 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.

**Attention Residents of CALIFORNIA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

**Attention Residents of 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.

**Attention Residents of DELAWARE, IDAHO and INDIANA:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Attention Residents of 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.

**Attention Residents of 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.

**Attention Residents of KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Attention Residents of MAINE, TENNESSEE, VIRGINIA and WASHINGTON:** 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.

**Attention Residents of MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***Effective January 1, 2013***
**Attention Residents of MARYLAND:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Attention Residents of MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Attention Residents of 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.

**Attention Residents of NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Attention Residents of OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Attention Residents of OKLAHOMA:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Attention Residents of PENNSYLVANIA:** Any person who knowingly and with the 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.

**Attention Residents of RHODE ISLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Attention Residents of TEXAS:** 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.

**Attention Residents of VERMONT:** Any person who knowingly, and with the intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.