wellabe®

Medico
Insurance Company
A Wellabe Company

Vision Insurance Claim Form

Submitted to Wellabe, Inc. (the "Company")*

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

Instructions for filing a claim

To avoid unnecessary processing delays, please provide all of the requested information:

- ❒ A completed and signed claim form.
- ❒ A completed and signed Claims HIPAA Authorization for Release of Protected Health Information (PHI) form.

We suggest you keep a copy of all the information you send for your records.

Warning

Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

Mail or fax the completed claim form and all other necessary documents to:

Wellabe, Inc.
P.O. Box 21660
Eagan, MN 55121

Fax: 402-496-8199

We're here for you:

If you have any questions, please call us at 800-228-6080, Monday - Friday, 7:30 a.m. to 5 p.m. Central time.

Our secure customer portal and Wellabe: Be Well mobile app provide 24/7 access to your plan. You can view plan coverage, benefits, deductibles, track claims status, pay premiums, download forms, connect with our support team, order a replacement ID card or share it digitally in the app; and more. Registering is easy. Simply visit www.wellabe.com/signin to login or register for an account.

Important message

Failure to submit ALL REQUIRED INFORMATION may delay processing this claim. To prevent possible delays, make sure to complete the claim form and include required health care provider documentation to support the claim. Written notification will be provided if additional information is needed to process a claim.

* Medico Insurance Company is a Wellabe company.

Vision Insurance Claim Form

(Please print all information.)

Insured information

Insured full name (*first, middle, last, suffix)* | Date of birth *(mm/dd/yyyy)* | Policy number

Address | Social Security number

City | State | ZIP code | Phone number

Patient information

Patient's full name (*first, middle, last, suffix)* | Date of birth *(mm/dd/yyyy)*

Patient's relationship to insured: ❒ Self ❒ Spouse ❒ Child ❒ Other

Diagnosis or Nature of Illness or Injury (Relate Diagnosis to Procedure Below)

Please select the appropriate diagnosis and procedure code for use in section below.

*Place of Service Codes:
10 Inpatient Hospital
20 Outpatient Hospital
30 Provider's Office
40 Patient's Home/Supply House

Diagnosis:
1 V72.0 Routine Eye Examination
2 367.0 Hypermetropia (Far-sightedness)
3 367.1 Myopia (Near-sightedness)
4 367.2 Astigmatism
5 367.4 Presbyopia
6 Other (Please specify with valid ICD-9 Code)

Procedure Codes:
1 92002 Eye Examination (Intermediate, New Patient)
2 92004 Eye Examination (Comprehensive, New Patient)
3 92012 Eye Examination (Intermediate, Established Patient)
4 92014 Eye Examination (Comprehensive, Established Patient)
5 92015 Refraction
6 Eyeglasses
7 Contacts
8 Other (Please specify with valid CPT Code)

Date(s) of Service MM/DD/YY	*Place of Service	Type of Service	Procedures, Services, or Supplies: Modifier	Procedures, Services, or Supplies: CPT or HCPCS Code	Diagnosis Code	Charges	OR Units	Leave Blank

Federal Tax I.D. Number ❒ SSN ❒ EIN	Patient's account number	Accept assignment? (for government claims) ❒ Yes ❒ No	Total charges $	Amount paid $	Balance due $

Signature of physician or supplier including degrees or credentials	Name and address of facility where services were rendered (if other than home or office)	Physician's, supplier's billing name, address, ZIP code, and phone number
Signed / Date		PIN# / GRP#

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

X _____ _____

Owner's signature | Date signed *(mm/dd/yyyy)*

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Claims HIPAA Authorization for Release of Protected Health Information (PHI)

By completing and signing this authorization, I, or my legal representative, authorize Wellabe, Inc. (the "Company")* and its affiliates, employees, agents and subcontractors, to receive, use and/or disclose my PHI as described below.

Policy/certificate number	
Full name of insured	Date of birth (mm/dd/yyyy)

1. Persons/class of persons authorized to receive, use, or make disclosure of PHI: **Any licensed medical professional, hospital, clinic, or other medical-related facility, pharmacy, pharmacy benefit managers, governmental agency, or insurance company.**
2. Specific description of PHI that may be received, used, or disclosed: **All medical and health information concerning advice, care or treatment provided. This includes information on the diagnosis and treatment of alcohol, drug use, test results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes.**
3. By signing this authorization, you understand and agree:
   a. PHI may be received, used, or disclosed for the purpose of processing claims for insurance benefits.
   b. This authorization is voluntary, and you may refuse to sign it. You further understand if you do not sign this authorization, we may not be able to process your claim for insurance benefits, resulting in a claim denial. You understand we require this PHI to determine claim eligibility.
   c. You are entitled to receive a copy of this signed authorization upon request.
   d. You may revoke this authorization at any time by sending written notification to the Company at: Wellabe, Inc; Attn: Claims; P.O. Box 1; Des Moines, Iowa 50306-0001. The revocation will not be valid if we or another third party has taken action in reliance on this authorization.
   e. PHI may potentially be redisclosed and no longer protected by federal privacy regulations.
   f. This authorization will expire 24 months from the date of signature.

_____

Signature of individual or personal representative *Date (mm/dd/yyyy)*

_____

Printed name of individual or personal representative

If a legal representative signed this form, describe the relationship: _____

If you are signing this authorization as a legal representative of the insured, you must provide legal documentation authorizing you to act on the insured's behalf (e.g. power of attorney, legal guardianship, personal representative, administrator, executor). By signing this authorization, you certify and attest that you are authorized to complete this due to your relationship to the insured.

* The Company includes, but is not limited to, American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company. American Republic Insurance Company administers for American Family Mutual Insurance Company, S.I., American Family Insurance Company, Continental General Insurance Company, Central Reserve Life Insurance Company, and Provident American Life Insurance Company. Medico Insurance Company administers for Ability Insurance Company and Knights of Columbus Health and Accident Division. Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company.

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.
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.
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.
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.
Kansas	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Maine, Tennessee, Virginia, and Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.
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.
Ohio	Any person who, with intent to defraud or knowing that he or she 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.
Oklahoma	Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law.
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.
Residents of All Other States	NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.
The furnishing of forms does not constitute an admission of liability on the part of the Company.	