MEDICO® INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 21660
Eagan, MN 55121
Phone: 1-800-228-6080
Fax: 1-402-496-8199

VISION INSURANCE CLAIM FORM

CLAIMANT'S PROOF OF LOSS

Insured's Name:_____ Date of Birth:_____ Policy No.:_____

Address:_____
Street City State Zip Code

Social Security No.:_____

Telephone #:_____

PATIENT INFORMATION

Patient's Name:_____
Last Name First Name

Patient's Relationship to Insured:
❒ Self ❒ Spouse ❒ Child ❒ Other

Sex:
❒ Male ❒ Female

Date of Birth:_____
Month/Day/Year

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) _____

A	B	C	D		E	F	G	H
DATE(S) OF SERVICE MM DD YY	*PLACE OF SERVICE	TYPE OF SERVICE	MODIFIER	PROCEDURES, SERVICES, OR SUPPLIES CPT OR HCPCS CODE	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK

FEDERAL TAX I.D. NUMBER	SSN ❒ EIN ❒	PATIENT'S ACCOUNT NO.	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 #
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.

Subscriber Signature _____ Date _____

over, please

HIPAA and MIB Authorization

HIPAA AUTHORIZATION

I authorize any person described below who has health or non-health information about me to disclose such information to Medico Insurance Company and/or Medico Corp Life Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. (180 days for confidential HIV-related information).
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

I agree that a copy of this Authorization is as valid as the original.

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

AUTHORIZATION TO DISCLOSE INFORMATION (MIB)

I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. ..... ☐ **Yes** ☐ **No**

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

If you are signing as a personal representative for an individual to be insured, read and sign below

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal Representative (Please print)

Personal Representative Signature

X

Person(s) to be Insured
(Please print)

1.

2.

My relationship to applicant(s)
(Please print)

1.

2.

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 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.