



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

HEARING 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 #: _____

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

- Name of Examiner: _____ License No.: _____
- Date of Most Recent Hearing Aid Test: _____
- Date of Prescription for Hearing Aid: _____
- In my professional opinion, a hearing aid is required is not required
- Hearing Loss (%) Left Ear _____% Right Ear _____%

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

- Hearing Aid Center: _____ License No.: _____
- Hearing Aid Type or Model: _____
- Cost of Hearing Aid Appliance \$ _____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

| DATE(S) OF SERVICE MM DD YY | PLACE OF SERVICE | TYPE OF SERVICE | PROCEDURES, SERVICES, OR SUPPLIES | | DIAGNOSIS CODE | CHARGES | OR UNITS | LEAVE BLANK |
|--------------------------------|------------------|-----------------|-----------------------------------|-------------------|----------------|---------|----------|-------------|
| | | | MODIFIER | CPT OR HCPCS CODE | | | | |
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| FEDERAL TAX I.D. NUMBER | SSN <input type="checkbox"/> | EIN <input type="checkbox"/> | PATIENT'S ACCOUNT NO. | ACCEPT ASSIGNMENT? (for government claims) <input type="checkbox"/> YES <input type="checkbox"/> 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 _____

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.

over, please

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 its 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

Your Name (Please print)

Your Signature

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

Your Spouse's Signature (if applying)

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

Your Name (Please print)

Your Signature

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

Your Spouse's Signature (if applying)

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)

Person(s) to be Insured
(Please print)

Personal Representative Signature

My relationship to applicant(s)
(Please print)