



**MEDICO®**

**INSURANCE COMPANY**

P.O. Box 10386, Des Moines, Iowa 50306-0386

## **Medico® Hospital Indemnity Claim Form**

### **What You Need to Know About Filing Your Claim**

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

1. A standard bill (UB04/HCFR 1500) or an itemized billing statement from your medical provider which contains the following information:
  - a. Diagnosis Codes
  - b. CPT and/or HCPCS Procedure Codes
  - c. Dates of Admission and Discharge
  - d. The number of Room and Board days being charged
  - e. If observation hours are being charged, we need to see the number of hours/units spent
2. A completed, signed Claim Form.
3. The HIPAA Authorization needs to be signed and dated so we can contact your medical provider on your behalf if additional information is needed.
4. If filing with a Cancer diagnosis, please include the pathology report.

**Please attach a standard bill (UB04/HCFR 1500) or an itemized billing statement from your medical provider that includes ICD-CM diagnostic codes.**

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

**Medico Insurance Company**

**P. O. Box 21660**

**Eagan, MN 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 further questions,  
please contact our Customer Care Center at*

**1-800-228-6080**



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**Please attach a standard bill (UB04/HCFR 1500) or an itemized billing statement from your medical provider that includes ICD-CM diagnostic codes.**

1. Patient's Name \_\_\_\_\_
2. Policy Number \_\_\_\_\_ 3. Patient's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_
4. Address \_\_\_\_\_  
Street City State ZIP
5. Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_
6. Date the Patient became ill with this condition \_\_\_\_ / \_\_\_\_ / \_\_\_\_
7. Reason for treatment \_\_\_\_\_
8. Date the Patient first saw any Physician for this condition \_\_\_\_ / \_\_\_\_ / \_\_\_\_
9. Name(s) and address(es) of Physician(s) who treated the Patient for this condition.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
11. Was the Patient 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 incapacitated, Parent or Guardian must sign. IF PATIENT IS DECEASED, Personal representative or Next of Kin must sign.)

**The Furnishing of the Form is not admission of any Liability on the part of the Company.**

**For your protection state law requires the following statements to appear on this form.**

**FRAUD WARNING STATEMENT**

<b>Alabama</b>	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.
<b>California</b>	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.
<b>Colorado</b>	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.
<b>District of Columbia</b>	<b>WARNING:</b> It is a crime to provide false or misleading information to an insurer for the <i>purpose of defrauding</i> 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.
<b>Florida</b>	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.
<b>Minnesota</b>	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>New Hampshire</b>	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."
<b>New York</b>	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.
<b>Pennsylvania</b>	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.
<b>Rhode Island</b>	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.
<b>Tennessee</b>	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.
<b>Residents of All Other States</b>	<b>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.</b>

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 10386**  
**Des Moines, IA 50306-0386**  
**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.***