Frequently Asked Questions
Claims

MEDICO®

1. **Q. What documentation is required to prove eligibility for benefits?**

A. A billing statement or invoice showing the service(s) received and the cost for the service(s) is required to process a claim.

The bill or invoice should contain the following information:

- Diagnosis code
- Date(s) of service
- Billed charge(s)
- Provider/facility name
- Provider/facility address

2. **Q. What is the process to submit a claim?**

A. The claim process will vary based on the insurance product. For specific details, follow the claim filing guidelines on the back of the ID card.

3. **Q. Is there a claim form? If so, where is it located?**

A. In most cases a claim form is not needed. If a form is needed, it can be found online at gomedico.com/policyholders/forms.

4. **Q. How will payment be received?**

A. In cases where payment is made directly to the policyholder, a check will be mailed.

If payment is sent to a provider, the method payment may be a check, virtual credit card (VCC), or electronic funds transfer (EFT). EFT payments are set up to go directly to the provider's bank account.

5. **Q. How long will it take for the claim to be processed?**

A. Medico follows Prompt Payment guidelines, which vary by state. Most Medicare Supplement claims are processed within 1–2 days after the claim is received. Claims requiring examiner intervention are generally processed within 10–14 days.

For Dental, Vision, and Hearing insurance benefits:

1. **Q. Is an itemized bill enough documentation to file a claim?**

A. Yes, an itemized bill showing the service(s) received and the cost for the service(s) is sufficient documentation to file a claim.

2. **Q. Can the provider submit the claim?**

A. Yes. In fact, most providers do submit claims by following the instructions printed on the back of the ID card. Policyholders can also file claims.

For Hospital Indemnity insurance benefits:

1. **Q. Is a hospital bill sufficient documentation to file a claim?**

   A. Uniform billing (UB) forms are considered appropriate documentation for filing a claim. Other bill formats are also acceptable if they contain key elements, including the diagnosis and the type of room charge billed (room and board or observation only).

2. **Q. Do we need the UB-04 form?**

   A. This specialized form is not always required; however, it is the best form to include when filing a claim.

3. **Q. For the transportation and lodging benefit, what documentation is needed to prove the policyholder lives 50 miles away from where treatment took place?**

   A. Because we know where the policyholder lives and where the treatment took place, we can calculate the mileage to determine eligibility for the benefit. The policyholder does need to provide a completed travel log when filing a claim for the travel benefit. This form can be found online at gomedico.com/policyholders/forms.

   For the lodging benefit, the policyholder should provide all receipts for their accommodations.

4. **Q. For the chiropractic benefit, is an itemized bill sufficient documentation?**

   A. Yes, an itemized document is necessary to process the claim payment.

For First Diagnosis Cancer insurance benefits:

1. **Q. Is a pathology report required to file a claim?**

   A. Yes, this documentation is necessary to process the claim payment.

For Short-Term Care or Short-Term Recovery Care insurance benefits:

1. **Q. Can an invoice or bill be submitted for prepayment?**

   A. Claims cannot be submitted for prepayment.

2. **Q. If I am released from care before reaching the lifetime maximum benefit of my policy, will I be able to use the remaining benefit in the future?**

   A. Yes, benefits will continue to be available, as needed, until you reach the lifetime maximum benefit.

3. **Q. What criteria is used for restoring my benefits?**

   A.
   - You must not require or receive treatment or services for the same cause(s) for which a previous benefit period began for a period of 180 consecutive days.
   - You must not have met the requirements for benefit eligibility under the policy for a period of 180 consecutive days.
   - You have not received care in a nursing home, assisted living, or hospice care facility and have not utilized home health care or adult daycare services or any combination of these services for a period of 180 consecutive days.

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