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<br>SIGNED DATE | 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 #<br>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

**Medico Insurance Company**
Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306-0386

**Medico Corp Life Insurance Company**
Corporate Office – Omaha, NE
Administrative Services – PO Box 10482
Des Moines, IA 50306-0482

# 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.