Dental Claimant's Statement

DIRECTIONS:

1. If this is a dental claim, and you have purchased the Dental Rider, please complete ALL PARTS of this form.

2. If this claim is a result of an accident, please visit www.hccmis.com, "Downloads" to obtain the ACCIDENT QUESTIONNAIRE, or contact our office to request the form.

3. If seeking reimbursement, attach all original itemized bills for services and supplies. Please verify that the documents indicate your name, date of service, diagnosis and the charge for each service. If dentist is billing us directly, please sign assignment of benefits authorization, and either attach dentist's bills, or dentist may submit separately.

4. **Mail to: HCC Medical Insurance Services**
   P.O. Box 863
   Indianapolis, Indiana 46206

5. If you have any questions, please call 1-800-605-2282. If calling from outside the US, call collect to (317) 262-2132.

****All Checks and Correspondence Will Be Sent To The Address Below****				
Insured Name:		Claimant (Patient) Name:		
Sex:	Birthdate:	Sex:	Birthdate:	
Street Address:		City:		Postal Code:
State:		Country:		
Home Telephone:	Work Telephone:	Fax Number:	E-mail address:	
Plan Number:		Certificate Number:		

1. Citizenship of Claimant: ____________ Home Country of Claimant: ________________
   (Country where you principally reside and receive regular mail)
   Country Visited: ________________________
   (HCCMIS may request a copy of your passport)

2. Is the Claimant: A full-time Student? ☐ Yes ☐ No If yes, please provide the name and address of school:____

3. Is the Claimant: Employed? ☐ Yes ☐ No If yes, please provide the name and address of employer:____

4. Do you or any family members have other dental coverage which might help cover dental expenses?
   ☐ Yes ☐ No If yes, please provide the following:

Name of Company:	Address:
Policyholder:	Policy Number:
Is this group insurance? ☐ Yes ☐ No	

I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to HCC Medical Insurance Services. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed:

Signature of Insured:	
Print Name:	Date:

Signature of Patient:	
Print Name:	Date:

ASSIGNMENT OF BENEFITS AUTHORIZATION: I authorize payment of medical benefits to the doctor or other supplier of services submitting the attached bills.

Signature of Insured:	Date:

INDIANA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.