

Dental, Vision & Hearing Expense Insurance Policy Claim Form

Please select the type of benefit you are filing: Dental Vision Hearing

PATIENT INFORMATION (COMPLETE ALL QUESTIONS)

1. Name: _____ **Policy Number:** _____
First, MI, Last

2. Address: _____
Street City State/Prov. Postal Code
 Email Address: _____

3. Date of Birth: ____/____/____ 4. Sex: Male Female 5. Phone: (____) _____
Month/Day/Year

Separate claim forms are required for each date of service you are filing.
Please provide an itemized statement from the Provider which includes a description of services rendered.

PLEASE COMPLETE IN FULL AND RETURN WITHIN 90 DAYS OF DATE OF SERVICE

Claim Information For DENTAL BENEFITS Check the item of service rendered.

6. Examination & Cleaning X-Rays Fillings Prophylaxis Other, please specify:
 Outpatient Dental Surgery Bridges Crowns Dentures

7. Date of Service: ____/____/____ _____
Month/Day/Year

Claim Information For VISION BENEFITS Check the item of service rendered.

8. Eye Examination or Eye Refraction Eye Glasses Contact Lenses Other, please specify:

9. Date of Service: ____/____/____ _____
Month/Day/Year

Claim Information For HEARING BENEFITS Check the item of service rendered.

10. Hearing Examination Hearing Aid Hearing Aid Repair Other, please specify:

11. Date of Service: ____/____/____ _____
Month/Day/Year

12. Name(s) of Provider providing services for this claim:

13. Address: _____ (____) _____
Street City State Zip Code Phone Number (including area code)

In Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
In Other States: Any person who knowingly and with intent to defraud any insurance company or other person, files a 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.

ANY COST FOR COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT

Date: ____/____/____ Signature: **X** _____
Month/Day/Year (Signature of Claimant or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to my physical or mental condition and/or treatment and any other non-medical information, to give The Order of United Commercial Travelers of America or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I am not required to sign this authorization form and that UCT will not condition the provision of payment for benefits to me on the signing of this authorization. However, UCT may condition payment of a claim for benefits on my authorization for disclosure of my information held by another person or entity, if such information is necessary to determine payment of a claim.

I agree that this authorization shall be valid for one year from the date shown below.

Release of all treatment records from: _____ to: _____
Month/Day/Year Month/Day/Year

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the *Notice of Privacy Practices* of UCT. I understand that I may revoke this authorization in writing at anytime, except to the extent that action has already been taken by UCT in reliance on this authorization, by sending a written revocation to UCT, Privacy Officer, 1801 Watermark Drive, Suite 100, Columbus, OH 43215.

Name of Insured: _____ Last four (4) digits of Social Security No.: _____

Date of Birth: ____/____/____
Month/Day/Year

Date: ____/____/____ Signature: **X** _____
Month/Day/Year (Signature of Insured or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

Please be sure to read the **LIMITATIONS and EXCLUSIONS section of your policy for additional information on eligible expenses.**