MediQ65®

Medicare Supplement Insurance

Underwritten by QualChoice Life and Health Insurance Company, Inc.

One More Reason to Smile with Your MediQ65 Plan

Preventive Dental Services Discounts

Procedures included (once every six months):

- Dental exam
- Teeth cleaning
- Bitewing X-ray
- Fluoride treatment

Members of all MediQ65 plans (except Plan F) are entitled to discounts on preventive dental services. Use any dentist and receive the discount just by presenting your MediQ65® ID card. There is no network, but most dentists accept this benefit. There is no deductible. Your dentist should send the claim directly to QualChoice.*

You may be balance billed if charges are greater than the discount amount paid by QualChoice, or if the dentist doesn't accept the discount. Be sure to check with your dentist when making your appointment.

These discounts are an added benefit to your MediQ65 plan – not a dental insurance plan. There is no additional charge for the benefit.

**Claims are paid according to market reimbursement. Your provider should use Payer ID# 35174. Claims must include specific dental codes: D0120, D0150, D0210, D0220, D0230, D0270, D0272, D0274, D1110, D1208.*

For questions about dental services or other MediQ65 benefits, contact our MediQ65 specialists:

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QualChoice® HEALTH INSURANCE

Call toll-free Monday – Friday 855.MEDIQ65 (855.633.4765) | MediQ65.com

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Dental Claim Form

Fill out this form only if your healthcare provider is not submitting the claim for you. See instructions for completing the form on the back.

Section I: Insured Information			
Insured's Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YYYY)	
Member's Mailing Address • Is this a new address? ☐YES ☐NO	City	State	ZIP
Member's QualChoice ID Number (on front of your ID card)	Daytime Telephone No.		

Section II: Patient Information *Complete this section **ONLY** if patient is not the Insured.*			
Patient's Name (Last, First, Middle Initial)	Relationship to Insured ☐Spouse ☐Dependent ☐Other	Date of Birth	Gender ☐Male ☐Female
Patient's Address (if different than employee address)	City	State	ZIP

Section III: Payment Instructions

I certify the above is complete and accurate. By signing below, I affirm in writing that I have not assigned QualChoice benefits to my healthcare provider.

Insured's Signature (Required)	Date (MM/DD/YYYY)

Important Information

1. The information provided on this form may be disclosed to other persons or entities, including plan sponsors, for the purpose of processing this claim and performing health plan administration.
2. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Dental Claim Form

INSTRUCTIONS

1. This form should be completed for dental claims only.

Please include an itemized bill from your dental provider. Itemized bills must contain the following information:

- Date of service
- Subscriber name and QualChoice ID number
- Member name and date of birth
- Procedure code
- Description
- Provider name, address, and phone number
- Provider ID
- Provider Taxpayer ID Number (TIN) or SSN
- Provider license number
- Amount charged for each service

2. An itemized bill must be submitted for your claim to be processed.

The following items are not acceptable documentation: cash register receipts, canceled checks, money order receipts, handwritten claims, or personal lists. The member must provide original documents.

3. The Dental Claim Form cannot be processed without the insured's ID number.

To process your claim we need the insured's QualChoice ID card. This number is located on the front of the insured's ID card.

4. A separate Dental Claim Form must be submitted for each eligible member.

NOTE: Only one claim form per member is needed regardless of the number of receipts.

5. Your claim may be rejected for the following reasons:

- If any information is missing, altered, or unclear.
- If claim form from the healthcare provider is handwritten.
- If claim form is not accompanied by an original itemized bill.
- If claim is submitted past the required time frame.
- If member has assigned QualChoice benefits to the healthcare provider.

6. You are encouraged to submit claim(s) within 60 days of the date of service.

Claims must be received by QualChoice within one year of the date of service to be eligible for payment.

7. Be sure to retain a copy of your bills for your record.

What to submit:	1. Dental Claim Form (completed and signed by insured) 2. Original itemized bill

8. Mailing Instructions

Please mail or fax completed form to:	**QualChoice** **ATTN: Claims Processing** P.O. Box 25610 Little Rock, AR 72221	**Fax: 833.681.2495**

NOTE:	Your plan documents describe covered services under your health plan. Submission of this form does not guarantee reimbursement. For questions, call Customer Service at 501.228.7111 or 800.235.7111, Monday through Friday, 8 a.m. to 5 p.m. CT.

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