



# Claim Form

## Dental, Vision and Hearing Medical Expense Reimbursement

(See Summary of Benefits for  
Coverage under your Plan)

**MAIL TO:**  
Fidelis Secure Care  
Attn: Claims  
PO Box 3597  
Scranton, PA 18505  
(847) 372-8085

### Member Information

Name: \_\_\_\_\_  
 Member ID: \_\_\_\_\_  
 Medicare Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

### Send Payment to:

**Same as Member Information**  
 -- If different, complete below --

Member Name: \_\_\_\_\_  
 c/o: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

### Expense Information

Please attach and submit the detailed receipts. Submission of receipts for reimbursement does not guarantee reimbursement. See Summary of Benefits for limits and maximums that may apply.

Description	Date of Purchase/Service	Amount Spent
1.) _____	_____	\$ _____
2.) _____	_____	\$ _____
3.) _____	_____	\$ _____
4.) _____	_____	\$ _____
5.) _____	_____	\$ _____

### Please Read

Reimbursement forms without the required information and proof of amount spent cannot be processed. Incomplete forms will be returned to you.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Your signature attests that all information, including the total charges is accurate.

\_\_\_\_\_  
 Member (or Responsible Party) Signature                      Date                      Telephone