Where to send your claim form:
DAS
PO BOX 7406
SIOUX FALLS SD 57117-7406

Fax: 605-274-3291

Or Scan and Email

state-customer-service@dakotacare.com

Attach a copy of:

☐ **Medical Claim** ☐ **Medication Receipt** ☐ **Invoice**

Ensure all items are legible and include:

☐ **Patient Name** ☐ **Date of Birth** ☐ **Service or Item Description**

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN MEDICAL CLAIM FORM

#1 GENERAL INFORMATION

Employee Name (Last) (First)	☐ Male ☐ Female	Date of Birth	Health Plan ID # from ID Card

Employee Street Address	City, State and Zip Code	Tel. No.

Name of Patient (if not employee)	Patient's Date of Birth	☐ Male ☐ Female	☐ Spouse ☐ Dependent

Description of Service/Item you are filing for coverage:

#2 Fill out this portion ONLY when the claim is for an accidental Injury or Illness.

Was your condition related to:

a. Employment? ☐ Yes ☐ No
(current or previous)

b. Auto Accident? ☐ Yes ☐ No

c. Other Accident? ☐ Yes ☐ No

If YES to a, b, or c on the left: please write a detailed description in this section of the form.

Date of the Accident__________/__________/__________

#3 Fill out this portion ONLY if the patient is a SPOUSE or CHILD and has ANOTHER GROUP HEALTH INSURANCE PLAN.

Name of Insured Person	Insured's Date of Birth	Group Number	Member ID# from ID Card

Name of Employer (other than the State of SD)	Address of that Employer

Name of the Other Insurance Company	Policy Effective Date	Address of Insurance

#4 READ AND SIGN WHERE INDICATED

In consideration of benefits payment under this Group Health Plan, the State shall have a lien upon any recovery for an injury or disease received from any person, or organization that was responsible for causing such injury or disease, or their insurers.

I authorize any physician or other medical professional, hospital or other medical care institution, insurer, medical or hospital service or prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator to disclose to the claim processor or any benefit plan administrator, or attorney acting on the claim processor's behalf, any medical information and any employment related information regarding the patient. This information will be used to evaluate and administer claims for benefits. This authorization is valid for the duration of the claim. I know that I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

Any person who knowingly files a statement of claim containing false, incomplete or misleading information with intent to injure, defraud, or deceive the State's Benefit Plan or any insurance company is guilty of a crime.

______________________________ ______________________________ ____________________
Patient's Signature (Parent, if Minor) Insured's Signature Date

Call this number when you have questions regarding plan provisions and claim issues

1-800-831-0785