Where to send your claim form:
DAKOTACARE
P.O. Box 7406
Sioux Falls, SD 57117-7406

CLAIM FORM
STATE OF SOUTH DAKOTA

Please check the appropriate benefit section(s) below:

- ❑ **Health Plan**
- ☐ **Health Reward & Wellness Account (HRWA)**
- ❑ **Health Reimbursement Account**
- ❑ **Opt-Out Credits**
- ❑ **Medical Expense Spending Account (on back)**
- ❑ **Dependent Care Spending Account (on back)**

#1 GENERAL INFORMATION

Employee Name (Last) (First)	☐ Male ☐ Female	Date of Birth	Employee SSN or Alternate ID#

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

Name of Patient (if not employee)	Patient's Date of Birth	Social Security Number	☐ Male ☐ Female	☐ Spouse ☐ Unmarried Child

If your spouse is a State Employee, please complete their full name and social security number.	Name	Spouse's Social Security Number

#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 any situation, 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	Date of Birth	Social Security Number

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

Name of the Other Insurance Company	Address of that Company

#4 READ AND SIGN WHERE INDICATED

In consideration of benefits payment under this Group Policy, the State shall have a lien upon any recovery for an injury or disease received from any person, or organization who 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.

I certify that the expenses for which reimbursement is requested under the Spending Account were incurred by myself or my eligible dependents or both. I will not use expenses reimbursed through the Spending Account as deductions when filing my individual income tax return. I understand that submission of this form does not serve as a guarantee for payment and that my claims are subject to the requirements of the Spending Account.

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

_____ _____ _____

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

GENERAL INFORMATION

- Keep copies of your medical bills for your records.
- If you are submitting copies, be sure they are clear and readable.
- Your medical bills or invoices are needed to substantiate your claim. Canceled checks or cash register receipts are NOT acceptable documentation to process a claim.
- Let your physician or pharmacist know in advance what information you will need to correctly file your claim.
- If a covered dependent is covered by two insurance plans, and you know that the other plan is primary, file with that plan first. Then file your claim with DAKOTACARE after the other plan has paid. Be sure to enclose a copy of the other plan's Explanation of Benefits (EOB).

SPENDING ACCOUNT PARTICIPANT'S SIGNATURE _____

SSN or Alternate ID #: _____

MEDICAL EXPENSE SPENDING ACCOUNT

To request reimbursement for medical expenses please answer the following questions.

1. Is the service you received eligible for coverage by any current Medical Insurance? ❑Yes ❑No
   (Attach Explanation of Benefits (EOB) if applicable.)

2. Is the service you received covered by any Dental or Vision Plan? ❑Yes ❑No
   (Attach Explanation of Benefits (EOB) if applicable.)

List the Name and Address of Service Provider*	Date of Service	Amount of Reimbursement Requested
TOTAL AMOUNT REQUESTED		$

* Attach Copy of Explanation of Benefits or Bill

DEPENDENT CARE SPENDING ACCOUNT

List the Name, Address, and Social Security or Tax ID Number of Service Provider(s)	Date of Service	Amount of Reimbursement Requested
TOTAL AMOUNT REQUESTED		$

TOLL FREE PHONE NUMBER
1.800.831.0785
Call this number when you have questions regarding plan provisions and claim issues.