



# Insurance Claim Form

**DENTAL**  **VISION**

Participant name (Please type or print): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Participant Address (complete only if new): \_\_\_\_\_  
 \_\_\_\_\_ City State Zip

Employer \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

By submitting this claim form, I certify and warrant to PIOPAC Fidelity that these services I or my dependents have incurred.

=>Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**LIST EACH CLAIM SEPARATELY**

Patient Name (A)	Provider Name (B)	Description of Service (C)	Dates of Service (D)	Claim Amount	PIOPAC Use Only

**TO SUBMIT YOUR COMPLETED FORM:**

**FAX** completed Insurance Claim form to: **(808) 536-0430**

*Note: Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to PIOPAC.*

**OR**

**MAIL** completed request for reimbursement forms to:

PIOPAC Fidelity  
 Claims Dept.  
 1132 Bishop Street, Suite 2101  
 Honolulu, HI 96813

**For Customer Service call: (808) 792-5226**

**FOR OUT-OF-POCKET EXPENSE NOT COVERED BY PLAN, YOU MUST USE  
 THE REQUEST FOR REIMBURSEMENT FORM**