

New York State Government Employees Health Insurance Program

HEALTH INSURANCE CLAIM FORM

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1. MEDICARE MEDICAID CHAMPUS CHAM (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #)	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBÉR	(FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD Y M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)			st Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
CITY STATE	Self Spouse Child Other 8. PATIENT STATUS	CITY	STATE
ZIP CODE TELEPHONE (Include Area Code)	Single Married Other	ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Employed Full-Time Part-Time Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP C	() OR FECA NUMBER
		30500 a. INSURED'S DATE OF BIRTH	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	MM DD YY	M SEX
b. OTHER INSURED'S BIRTH DATE SEX b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME MM F NO L J SEX D SEX			
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME EMPIRE PLAN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH B	SENEFIT PLAN? f yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.			
SIGNED	DATE	SIGNED	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY(Accident) OR PREGNANCY (LMP)	. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO MM DD YY FROM) WORK IN CURRENT OCCUPATION. MM DD YY TO
	A. ID NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES R	ELATED TO CURRENT SERVICES. MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	\$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1	2,3 OR 4 TO ITEM 24E BY LINE)		<u> </u>
3		23. PRIOR AUTHORIZATION NUMBER	
2. B C	4 D E		H I J K
From To of Of (Exp	DURES, SERVICES, OR SUPPLIES ain Unusual Circumstances) PCS MODIFIER DIAGNOSIS CODE	CHARGES OR Fa	PSDT ramily EMG COB RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt. claims)		AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		\$ \$ \$ 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
SIGNED DATE		PIN#	GRP#

INSURANCE FRAUDS PREVENTION ACT

The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

PLEASE MAIL CLAIMS TO: United HealthCare Insurance Company of New York

P.O. Box 1600 Kingston, New York 12402-1600 1-877-7NYSHIP (1-877-769-7447)