



New York State Government Employees Health Insurance Program

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            CHAMPUS <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (VA File #)            GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID)            FECA BLK LUNG <input type="checkbox"/> (SSN)            OTHER <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD Y		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
CITY			STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE											
ZIP CODE			TELEPHONE (Include Area Code) ( )			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (Include Area Code) ( )											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER <b>30500</b>											
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY    M <input type="checkbox"/> F <input type="checkbox"/>											
b. OTHER INSURED'S BIRTH DATE MM DD YY    M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State) _____						b. EMPLOYER'S NAME OR SCHOOL NAME											
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME <b>EMPIRE PLAN</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>											
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE					
SIGNED _____												DATE _____						SIGNED _____					
14. DATE OF CURRENT: MM DD YY				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION. FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17A. ID NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY											
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO    \$ CHARGES _____						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)											
1. _____						3. _____						23. PRIOR AUTHORIZATION NUMBER											
2. _____						4. _____						24. A											
DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS   MODIFIER				E DIAGNOSIS CODE		F CHARGES		G DAYS OR UNITS		H EPSDT Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE	
1																							
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$		29. 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# _____					

PLEASE ASK PROVIDER TO TYPE THIS FORM

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

**INSURANCE FRAUDS PREVENTION ACT**

~~February 6, 2006~~

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)