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## New York State Government Employees **Health Insurance Program**

## 1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA 1. MEDICARE CHAMPVA MEDICAID FRICARI OTHER 1a INSURED'S LD NUMBER (For Program In Item 1) BLK LUNG CHAMPUS HEALTH PLAN (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MM DD Υ М F 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) Spouse Child Self Other PATIENT AND INSURED INFORMATION STATE 8. PATIENT STATUS CITY STATE Single Married Other ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) Full-Time Part-Time Employed Student Student 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 30500 a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH MM DD SEX **TYES** I NO Μ F b. OTHER INSURED'S BIRTH DATE b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME SEX MM DD YY YES NO Μ F NSURANCE PLAN NAME OR PROGRAM NAME C. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? **EMPIRE PLAN** YES NO d. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 10d. RESERVED FOR LOCAL USE YES NO If ves, return to and complete item 9 a-d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment payment of medical benefits to the undersigned physician or supplier for services described below. below SIGNED DATE SIGNED 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS 14. DATE OF CURRENT: ILLNESS (First symptom) OR 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD YY PREGNANCY (LMP) INJURY(Accident) OR GIVE FIRST DATE MM ; DD MM FROM ТО 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. FROM ТО 17b. NPI \$ CHARGES 19. RESERVED FOR LOCAL LISE 20 OUTSIDE LAB? YES NO 22. MEDICAID RESUBMISSION CODE 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ORIGINAL REF. NO. 3. L 23. PRIOR AUTHORIZATION NUMBER PHYSICIAN OR SUPPLIER INFORMATION 4. 24. A В D Е G Н J PROCEDURES, SERVICES, OR SUPPLIES Place of DATE(S) OF SERVICE DAYS FPSDT ID DIAGNOSIS RENDERING OR From (Explain Unusual Circumstances) \$ CHARGES Family Plan QUAL CPT/HCPCS POINTER PROVIDER ID # EMG Service MODIFIER DD YΥ MM DD ΥY NPI NPI NPI NPI NPI NPI 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE YES NO \$ SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY INFORMATION 33. BILLING PROVIDER INFO & PH # ( ) b. а. a. b. SIGNED DATE

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

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)