**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. **MEDICARE** | **MEDICAID** | **TRICARE** | **CHAMPVA** | **GROUP** | **PEOA** | **BLK-LUNG** | **OTHER** | **INSURED’S S.I.D. NUMBER** *(For Program In Item 1)*
---|---|---|---|---|---|---|---|---

2. **PATIENT’S NAME** *(Last Name, First Name, Middle Initial)*

3. **PATIENT’S ADDRESS** *(No., Street)*

4. **PATIENT’S BIRTH DATE**

5. **SEX**

6. **PATIENT RELATIONSHIP TO INSURED**

7. **INSURED’S ADDRESS** *(No., Street)*

8. **INSURED’S NAME** *(Last Name, First Name, Middle Initial)*

9. **IS PATIENT’S CONDITION RELATED TO:**

10. **EMPLOYMENT?** *(Current or Previous)*

11. **INSURED’S POLICY GROUP OR PEOA NUMBER**

12. **INSURED’S DATE OF BIRTH**

13. **INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**

14. **DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP):**

15. **OTHER DATE**

16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:**

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.**

19. **ADDITIONAL CLAIM INFORMATION** *(Designated by NUCC)*

20. **OUTSIDE LAB?**

21. **DIAGNOSIS OR NATURE OF ILLNESS or INJURY.** *(Relate A-L to service line below (24E)) ICD Ind.

22. **RESUBMISSION CODE**

23. **PRIOR AUTHORIZATION NUMBER**

24. **DATE(S) OF SERVICE**

25. **FEDERAL TAX I.D. NUMBER**

26. **PATIENT’S ACCOUNT NO.**

27. **ACCEPT ASSIGNMENT?** *(For govt. claims, see back)*

28. **TOTAL CHARGE**

29. **AMOUNT PAID**

30. **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)*

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INFORMATION**

32. **SERVICE FACILITY LOCATION INFORMATION**

33. **BILLING PROVIDER INFO & PH #**

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0938-1197 FORM 1500 (02-12)**
<table>
<thead>
<tr>
<th>INSURANCE FRAUDS PREVENTION ACT</th>
</tr>
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<tbody>
<tr>
<td>The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department:</td>
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<tr>
<td>“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.”</td>
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</table>

For claims rendered or billed outside of NYS:

**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:** UnitedHealthcare  
P.O. Box 1600  
Kingston, New York 12402-1600  
1-877-7NYSHIP (1-877-769-7447)  
OR FAX TO (845) 336-7716