

## New York State Government Employees Health Insurance Program

	TEALIT IN	ISURANCE CLA	IIAI LOKIAI
1. MEDICARE MEDICAID CHAMPUS CHAM	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File 4 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, Fir	rst Name, Middle Initial)
		7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other		
OTY STATE		CITY	STATE
IP CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
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 O	( )
10. IS FATIENT 3 CONDITION RELATED TO.		30500	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM   DD   YY	SEX -
OTHER INSURED'S BIRTH DATE  MM DD W SEX		b. EMPLOYER'S NAME OR SCHO	M F F OL NAME
M F	YES NO L		
:. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	C. INSURANCE PLAN NAME OR F	PROGRAM NAME
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH	
READ BACK OF FORM BEFORE COMPLETE	ING & SIGNING THIS FORM.	YES NO	If yes, return to and complete item 9 a-d.  DEFRSON'S SIGNATURE
<ol><li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the process this claim.</li></ol>			
NOVED	DATE	OLONES	
	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO	O WORK IN CURRENT OCCUPATION.
MM   DD   YY   INJUHY(Accident) OR   PREGNANCY (LMP)   7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   17	GIVE FIRST DATE MM   DD   YY	FROM	TO
The second of th	A. IS NOWBERT OF THE ENTING THE GRANT	FROM PROMISE	MM   DD   YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	\$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1	1,2,3 OR 4 TO ITEM 24E BY LINE)		
1 3		23. PRIOR AUTHORIZATION NUMBER	
2		23. PHIOR AUTHORIZATION NO	INIDEN
	D E DURES, SERVICES, OR SUPPLIES		H I J K
From To of of (Exp. MM DD YY MM DD YY Service Service CPT/HC	olain Unusual Circumstances) DIAGNOSIS CPCS   MODIFIER CODE		Family EMG COB RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER SSN EIN   26. PATIENT'S	ACCOUNT NO. 27 ACCEPT ACCIONMENTS	28. TOTAL CHARGE 29	, AMOUNT PAID 30. BALANCE DUE
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?  (For govt. claims)  YES NO		\$   \$	1
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

1-800-942-4640