



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"/>	
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"/>	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code) ( )		TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>30500</b>	
b. OTHER INSURED'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>EMPIRE PLAN</b>	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, return to and complete item 9 a-d.</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: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		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)		23. PRIOR AUTHORIZATION NUMBER	
1. _____		3. _____	
2. _____		4. _____	
24. A		B	
DATE(S) OF SERVICE From To MM DD YY MM DD YY		Place of Service	
C		D	
Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER	
E		F	
DIAGNOSIS CODE		CHARGES	
G		H	
DAYS OR UNITS		EPSDT Family Plan	
I		J	
EMG		COB	
K		RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER    SSN    EIN		26. PATIENT'S ACCOUNT NO.	
<input type="checkbox"/> <input type="checkbox"/>		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# _____	

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PLEASE ASK PROVIDER TO TYPE THIS FORM

**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)