



New York State Government Employees Health Insurance Program

HEALTH INSURANCE CLAIM FORM

1. MEDICARE  (Medicare #) MEDICAID  (Medicaid #) CHAMPUS  (Sponsor's SSN) CHAMPVA  (VA File #)  GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG  (SSN) OTHER  (ID)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single  Married  Other

CITY STATE

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 **30500**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS)  YES  NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M  F

b. OTHER INSURED'S BIRTH DATE MM DD YY M  F

b. AUTO ACCIDENT?  YES  NO PLACE (State) \_\_\_\_\_

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?  YES  NO

c. INSURANCE PLAN NAME OR PROGRAM NAME **EMPIRE PLAN**

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO *If yes, return to and complete item 9 a-d.*

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 \_\_\_\_\_

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?  YES  NO \$ CHARGES \_\_\_\_\_

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

23. PRIOR AUTHORIZATION NUMBER

24. A	DATE(S) OF SERVICE			B	C	D	E	F	G	H	I	J	K
	From	To	MM DD YY										
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)  YES  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