



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

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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 M <input type="checkbox"/> SEX F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																
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"/>		7. INSURED'S ADDRESS (No., Street)																
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE												
ZIP CODE		TELEPHONE (Include Area Code) ()			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			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) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>															
b. OTHER INSURED'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____			b. EMPLOYER'S NAME OR SCHOOL NAME															
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes , 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															
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 INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			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? <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		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From MM DD YY To MM DD YY																					
1																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		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# _____												

PLEASE ASK PROVIDER TO TYPE THIS FORM

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 Service Corp.
Administrator for MetLife
P.O. Box 1600
Kingston, New York 12402-1600
1-800-942-4640