| HEALTH INSURANCE CLAIM FORM | | Health Insurance Program UnitedHealthcare P.O. Box 1600 Kingston, New York 12402-1600 1-877-7NYSHIP (1-877-769-7447) OR FAX TO (845) 336-7716 PICA |
|---|--|---|
| 1. MEDICARE MEDICAID TRICARE CHAMPVA (Medicare #) (Medicaid #) (Member IL | GROUP FECA OTHER HEALTH PLAN BLK LUNG 0 #) (<i>ID</i> #) (<i>ID</i> #) (<i>ID</i> #) | 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 SEX MM DD YY | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) |
| ITY STATE | Self Spouse Child Other 8. RESERVED FOR NUCC USE | CITY STATE |
| | _ | |
| P CODE TELEPHONE (Include Area Code) () | | ZIP CODE TELEPHONE (Include Area Code) |
| 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 |
| OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH SEX |
| RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) |
| | | |
| RESERVED FOR NUCC USE | - C. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME EMPIRE PLAN |
| INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes , complete items 9, 9a and 9d. |
| READ BACK OF FORM BEFORE COMPLETIN | G & SIGNING THIS FORM. | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the rele process this claim. I also request payment of government benefits either to | ase of any medical or other information necessary to o myself or to the party who accepts assignment below. | payment of medical benefits to the undersigned physician or supplier for services described below. |
| SIGNED | DATE | SIGNED |
| . DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP): MM DD YY QUAL | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION. MM DD YY MM DD YY FROM TO |
| 7. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. |
| ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | NPI | FROM TO 20. OUTSIDE LAB? \$ CHARGES YES NO |
| I. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service | line below (24E) ICD Ind. | 22. RESUBMISSION ORIGINAL REF. NO. CODE |
| A B C E. F. G. | D. [H. | 23. PRIOR AUTHORIZATION NUMBER |
| I J K | L [| 23. PRIOR AUTHORIZATION NUMBER |
| | URES, SERVICES, OR SUPPLIES ain Unusual Circumstances) DIAGNOSIS POINTER | F G H I J DAYS EPSDT ID RENDERING OR Family QUAL PROVIDER ID. # |
| | | |
| | | |
| | | NPI |
| | | |
| 5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AU | | 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use |
| | (For govt. claims, see back) YES NO | \$ |
| . 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.) | SILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # () |
| IGNED DATE a. | ipi b. | a. NPI b. |
| | | |

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