# New York State Government Employees Health Insurance Program

## Health Insurance Claim Form

### 1. Medicare, Medicaid, CHAMPUS, CHAMPVA, Group Health Plan, FECA, BLK Lung, Other

- Medicare #
- Medicaid #
- Sponsor's SSN (or VA File #)
- (SSN or ID)
- (ID)

### 2. Patient's Name (Last Name, First Name, Middle Initial)

### 3. Patient's Birth Date

- MM
- DD
- YY

### 4. Insured's Name (Last Name, First Name, Middle Initial)

### 5. Patient's Address (No., Street)

### 6. Patient's Relationship to Insured

- Self
- Spouse
- Child
- Other

### 7. Insured's Address (No., Street)

### 8. Insured's Policy Group or FECA Number

### 9. Other Insured's Name (Last Name, First Name, Middle Initial)

### 10. Other Insured's Policy or Group Number

### 11. Insured's Date of Birth

- MM
- DD
- YY

### 12. Insured's Name (Last Name, First Name, Middle Initial)

### 13. Insured's Date of Birth

- MM
- DD
- YY

### 14. Name of Referring Physician or Other Source

### 15. ID Number of Referring Physician

### 16. Diagnosis or Nature of Illness or Injury (Relate items 1, 2, 3, or 4 to item 24E by line)

1. 
2. 
3. 
4. 

### 17. Dates Patient Unable to Work in Current Occupation

- MM
- DD
- YY

### 18. Dates of Service

- MM
- DD
- YY

### 19. Procedure, Services, or Supplies

- Type of Service
- CPT/HCPCS
- Modifier
- Days or Units

### 20. EPSDT Family Plan

### 21. Total Charge

### 22. Amount Paid

### 23. Balance Due

### 24. Signature of Physician or Supplier

### 25. Federal Tax I.D. Number

### 26. Patient's Account No.

### 27. Accept Assignment?

- 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

### Please ask provider to type this form
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)