New York State Government Employees
Health Insurance Program

HEALTH INSURANCE CLAIM FORM

1. MEDICARE
   - Medicare #: [ ]
2. MEDICAID
   - Medicaid #: [ ]
3. CHAMPUS
   - SCHIP #: [ ]
4. CHAMPVA
   - (Name of Sponsor) #: [ ]
5. GROUP HEALTH PLAN
   - Health Plan #: [ ]
6. OTHER
   - Other #: [ ]

10. IS PATIENT'S CONDITION RELATED TO:
   - EMPLOYMENT?
     - YES [ ]
     - NO [ ]
   - AUTO ACCIDENT?
     - YES [ ]
     - NO [ ]
   - OTHER?
     - YES [ ]
     - NO [ ]

11. INSURED'S DATE OF BIRTH
   - MM: [ ]
   - DD: [ ]
   - YYYY: [ ]
   - SEX: M [ ]
   - F [ ]

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

14. DATE OF CURRENT ILLNESS
   - MM: [ ]
   - DD: [ ]
   - YYYY: [ ]

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
   - YES [ ]
   - NO [ ]

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   - FROM MM: [ ]
   - DD: [ ]
   - YYYY: [ ]
   - TO MM: [ ]
   - DD: [ ]
   - YYYY: [ ]

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

24. A DATE(S) OF SERVICE
   - MM: [ ]
   - DD: [ ]
   - YYYY: [ ]
   - CODE: [ ]

25. FEDERAL TAX I.D. NUMBER
   - SSN: [ ]
   - EIN: [ ]

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
   - [ ]

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 #

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 1-800-942-4640