-CARRIER-



PO BOX 1407, CHURCH STREET STATION NEW YORK NY 10008-1407 For services rendered out of area, provider should submit claim to the local Blue Cross and Blue Shield plan.

F F	PICA  HEALTH INSURANCE CLAIM FORM  1. MEDICARE MEDICAID CHAMPUS CHAMPUS GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (Include prefix) (FOR PROGRAM IN ITEM 1)														$\neg \neg \forall$						
1. MEDIC	CARE	N	1EDICAI	D	CHAM	PUS		CHAMPVA		GROUP HEALTH		ECA OTHER LK LUNG	1a. INSURED'	S I.D. NUN	√BER (Ir	nclude pr	refix) (	FOR PR	OGRAM	IN ITEM	1)
(Medic	care #)	(/	Medicai	d#) [	(Spons	sor's SSI	V)	(VA File #)		(SSN or											
2. PATIEN	IT'S N	AME (La	ast Nam	e, First N	Name, M	1iddle Ini	tial)		3. PATIENT'S BIRTH DATE  MM   DD   YY   SEX   F				4. INSURED'S NAME (Last Name, First Name, Middle Initial)								
5. PATIENT'S ADDRESS (No. Street)										IENT RE	ELATIONSHIP T	7. INSURED'S ADDRESS (No. Street)									
										Self Spouse Child Other											
CITY STATE										TENT ST			CITY STATE								
										Single [	Married [	Other									\{
ZIP CODE	E			TELE	EPHONE	(Include	e Area Co	ode)	Employed Full-Time Part-Time Student				ZIP CODE TELEPHONE (Include Area Code)							INFORMAT	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										PATIEN	T'S CONDITION									RED IN	
a. OTHER INSURED'S POLICY OR GROUP NUMBER										PLOYMI	ENT? (Current o	r Previous)	a INCLIDED'S DATE OF BIDTH								
											□YES	□NO	MM DD YY SEX M□ F□								ISN
b. OTHER				F BIRTH		CEV			b. AU		IDENT?	PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME								AND
MM   DD   YY   SEX   M□				F 🗌		□YES □NO												[4			
c. EMPLOYER'S NAME OR SCHOOL NAME									c. OTI	HER AC	CIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME								
											YES	□NO									ATI
d. INSURANCE PLAN NAME OR PROGRAM NAME									d. RES	SERVED	FOR LOCAL U	SE	d. IS THERE ANOTHER NAME OR BENEFIT PLAN?								<b>□</b> ↑
													□YES □NO								
READ BACK OF FORM BEFORE COMPLE 12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON TH													INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
SIGNED										DAT	E		SIGNED								
									F PATIE	NT HAS		R SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION								<u> </u>
MM DD YY INJURY (Accident) OR PREGNANCY (LMP)								(	GIVE FI	RST DA	TE MM [	DD YY	FROM DD YY TO MM DD YY								1
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a.									I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM; DD; YY  MM; DD; YY								
													FROM TO								
19. RESERVED FOR LOCAL USE														20. OUTSIDE LAB? \$ CHARGES							
												☐YES ☐NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2,										3 OR 4 TO ITEM 24E BY LINE) —				22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.							
1 3									s. L												
													23. PRIOR AUTHORIZATION NUMBER								
2.							0 1		4			☐ F	F G H I I J K								_  გ
	A DA	B C DATE(S) OF SERVICE PLACE TYPE PROCEDU			RES, SE	D RVICES	, OR SUPPLIES	3	F	DAYS I				PSDT							
MM F	ROM DD	TO OF OF YY MM DD YY SERVICESERVICE		(EXPLAIN I	JNUSU CS	IAL CIRO MO	CUMSTANCES) ODIFIER	DIAGNOSIS CODE			OR UNITS	OR FAMILY EN JNITS PLAN		G COB F							
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25. FEDE	KAL TA	4X I.D. Î	NUMBE	К	_	EIN	26. P/	atient's ac	COUN	ı NO.		EPT ASSIGNMENT?	28. TOTAL CH	ARGE 		<b>29</b> . AMO	UNI PA	ן ווי		ANCE DU	E
21 SIGNATURE OF PHYSICIAN OR SURPLIED 32 NAME AND A									DDDEC	S OF F	YES		\$ \$ \$ \$ \$ \$ 33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE								_
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  1 CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED											- SERVICES WERE	& PHONE			DILLING	NAIVIE,	ADDKES	JS, ZIP (	JUDE		
ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES																					
INDICA																					
CICNED													1077								

## PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any health care provider, payor of health claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

## **INSURANCE FRAUD STATEMENT**

The New York State Department of Insurance requires we notify you that "any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 \$5,000 and the stated value of the claim for each such violation."