

New York State Government Employees Health Insurance Program

UnitedHealthcare

P.O. Box 1600 HEALTH INSURANCE CLAIM FORM Kingston, New York 12402-1600 1-877-7NYSHIP (1-877-769-7447) 1a. INSURED'S I.D. NUMBER (For Program In Item 1) 1 MEDICARE MEDICAID TRICARE BLK LUNG HEALTH PLAN (ID #) (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID #) (ID #) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SFX 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 8. RESERVED FOR NUCC USE STATE CITY STATE PATIENT AND INSURED INFORMATION ZIP CODE TELEPHONE (Include Area Code) 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. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH MM ; DD ; YY a. OTHER INSURED'S POLICY OR GROUP NUMBER SFX YES М F b. AUTO ACCIDENT? PLACE (State) b. RESERVED FOR NUCC USE b. OTHER CLAIM ID (Designated by NUCC) YES ☐ NO OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME c. RESERVED FOR NUCC USE YES ☐ NO **EMPIRE PLAN** 10d. CLAIM CODES (Designated by NUCC) d. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? If yes, complete items 9, 9a and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. 15. OTHER DATE 14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD OUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. 17a. ММ 17b. NPI TO 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (Relate A-L to service line below (24F) 22. RESUBMISSION ORIGINAL REF. NO ICD Ind. G. | 23. PRIOR AUTHORIZATION NUMBER L. PHYSICIAN OR SUPPLIER INFORMATION D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) G DAYS OR DATE(S) OF SERVICE RENDERING ID QUAL Place of Service DIAGNOSIS Family PROVIDER ID. # \$ CHARGES CPT/HCPCS MODIFIER NPI NPI NPI NPI NPI NPI EIN ACCEPT ASSIGNMENT? 29. AMOUNT PAID 30. Rsvd for NUCC Use (For govt. claims, see back)
YES N 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED

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NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

PLEASE MAIL CLAIMS TO: UnitedHealthcare P.O. Box 1600

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