

PO BOX 5078
 MIDDLETOWN, NY 10940-9078
 1-800-934-7703



Note: Important filing instructions on next page

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) PYB	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No. Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code)	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER NEW YORK MEDICAL COLLEGE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME NEW YORK MEDICAL COLLEGE	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME NEW YORK MEDICAL COLLEGE-PPO PLAN	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER NAME OR BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. RESERVED FOR LOCAL USE	

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM. READ BACK OF FORM BEFORE COMPLETING THIS FORM. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED NOT APPLICABLE	
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14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	

19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> 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.	
23. PRIOR AUTHORIZATION NUMBER			

A		B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE		PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT FAMILY PLAN	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY							
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS "I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED." SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)				33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER PIN# _____ GRP# _____			

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN SUPPLIER INFORMATION ↓

FILING INSTRUCTIONS

MEMBERS: You are required to complete this claim form if you receive services from a nonparticipating physician (any physician that is “out-of-network”).

1. Complete the patient and insured information sections (**Boxes 1–12**).
 - Please make sure the three-letter alpha prefix, along with the insured’s member identification number, appears in **Box 1a**. **Do not complete Box 13**.
2. Attach the original itemized bill from the physician to the claim form and mail it to the address listed on the front of the form.

OR

Have the physician complete the physician supplier information sections (**Boxes 14–33**). And mail it to the address listed on the front of the form.

NOTE: If you receive services from a participating physician (an “in-network” physician), you are not required to complete any claim forms. All participating network physicians submit claims directly to their local Blue Cross and/or Blue Shield plan.

If you have any questions about completing this claim form, please call the Customer Service telephone number listed on the front of the form or the number on the back of your member identification card.

PROVIDERS: If you have rendered services to a member, please complete the physician supplier information sections (**Boxes 14–33**). Then mail it to the address listed on the front of the form.

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 healthcare provider, payor of health claims or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, or 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.

FRAUD STATEMENT

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, may be guilty of a criminal act punishable under law and may be subject to civil penalties.