THE EMPIRE PLAN

New York State Government Employees
Health Insurance Program

1500

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
□ (Medicare #)	□ (Medicaid #)	□ (Sponsor's SSN)	□ (Memberchip ID#)	☒ (SSN or ID)	□ (SSN)	□ (ID)

1a. INSURED'S I.D. NUMBER   (For Program In Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD Y   SEX M □ F □

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self □ Spouse □ Child □ Other □

7. INSURED'S ADDRESS (No., Street)

CITY   STATE

8. PATIENT STATUS
Single □ Married □ Other □
Employed □ Full-Time Student □ Part-Time Student □

CITY   STATE

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. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
□ YES □ NO

a. INSURED'S DATE OF BIRTH MM DD YY   SEX M □ F □

b. OTHER INSURED'S BIRTH DATE MM DD YY   SEX M □ F □

b. AUTO ACCIDENT?   PLACE (State)
□ YES □ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
□ YES □ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
EMPIRE PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
□ YES □ NO   *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

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 _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY(Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION. MM DD YY   MM DD YY
FROM   TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.
17b. NPI

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)

1. |___.___| 3. |___.___|
2. |___.___| 4. |___.___|

22. MEDICAID RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE						B Place of Service	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID. #
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER						
1														NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER   SSN □ EIN □

26. PATIENT'S ACCOUNT N0.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
□ YES □ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. SERVICE FACILITY INFORMATION

a. NPI   b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI   b.

PHYSICIAN OR SUPPLIER INFORMATION

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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)