[redacted]

Empire BlueCross BlueShield

PO BOX 5047
MIDDLETOWN NY 10940-9047
FOR CUSTOMER SERVICE: 1-800-635-2184

APPROVED OMB-0938-0008

**NOTE: Important filing instructions on next page.**

CARRIER

PICA

# HEALTH INSURANCE CLAIM FORM

PICA

## PATIENT AND INSURED INFORMATION

| 1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) |
|---|---|
| ☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☒ (SSN or ID) ☐ (SSN) ☐ (ID) | NYN |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐ |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 5. PATIENT'S ADDRESS (No. and Street) | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ |
| 7. INSURED'S ADDRESS (No. and 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 | 292261 |
| 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 DATE OF BIRTH MM DD YY SEX M ☐ F ☐ | b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO |
| b. EMPLOYER'S NAME OR SCHOOL NAME | VERIZON |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? ☐ YES ☐ NO |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | d. RESERVED FOR LOCAL USE |
| d. IS THERE ANOTHER NAME OR BENEFIT PLAN? ☐ YES ☐ NO If YES, return to and complete item 9a–d. | |

**READ BACK OF FORM BEFORE COMPLETING THIS SECTION.**

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM 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 _____

## PHYSICIAN SUPPLIER 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 FROM 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 MM DD YY FROM TO MM DD YY |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES |
| 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 FROM MM DD YY TO MM DD YY | B PLACE OF SERVICE | C TYPE OF SERVICE | D PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT FAMILY PLAN | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

| 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, 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 AND PHONE NUMBER PIN# GRP# |
|---|---|---|

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500



DSC 0431E 12/04

## 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.