

Important filing instructions on next page

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NEW YORK NY 10008-1407
1-800-939-7515



SUFFOLK COUNTY
EMHP
Employee Medical Health Plan of Suffolk County

PICA		HEALTH INSURANCE CLAIM FORM						PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDIKAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (Include prefix) (FOR PROGRAM IN ITEM 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
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"/>				7. INSURED'S ADDRESS (No. Street)																			
CITY				STATE				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE											
ZIP CODE				TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>				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																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO																			
READ BACK OF FORM BEFORE COMPLETING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.												NOT APPLICABLE															
SIGNED _____ DATE _____												SIGNED _____															
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 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																											
24. TABLE																											
A		B		C		D		E		F		G		H		I		J		K							
DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY		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							
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.*												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)															
SIGNED _____ DATE _____												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.