-CARRIER-



PO BOX 1407, CHURCH STREET STATION NEW YORK NY 10008-1407 For services rendered out of area, provider should submit claim to the local Blue Cross and Blue Shield plan.

PIC	PICA HEALTH INSURANCE CLAIM FORM 1. MEDICARE MEDICAID CHAMPUS CHAMPUS GROUP FECA OTHER 11a. INSURED'S I.D. NUMBER (Include prefix) (FOR PROGRAM IN ITEM 1)														$\neg \neg \forall$						
1. MEDICA	RE	MEDICA	ID	CHAM	PUS		CHAMPVA		GROUP HEALTH I		CA OTHER K LUNG	1a. INSURED'S	S I.D. NUN	∕IBER (Ir	nclude pr	refix) (FOR PR	OGRAM	IN ITEM 1) 🛦	
(Medicar	re #)	(Medicai	d #) _	(Spons	sor's SSI	V)	(VA File #)		SSN or I												
2. PATIENT	S NAME (I	_ast Nam	e, First I	Name, M	1iddle Ini	tial)		3. PATIENT'S BIRTH DATE MM DD YY SEX F				4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT	S ADDRES	SS (No. S	treet)					6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No. Street)									
								Self Spouse Child Other													
CITY							STATE		IENT STA			CITY STATE									
								5	Single _	Married [Other									_ ₹	
ZIP CODE			TELE	EPHONE	(Include	e Area Co	ode)	Employed Full-Time Part-Time Student				ZIP CODE TELEPHONE (Include Area Code)							INFORMAT		
9. OTHER II	NSURED'S	NAME (Last Nar	ne, First	Name, N	Middle In	itial)	10. IS PATIENT'S CONDITION RELATED TO:												RED IN	
a. OTHER II	NSURED'S	POLICY	OR GR	OUP NU	MBER			a. EMPLOYMENT? (Current or Previous)				a INCLIDED'S DATE OF BIDTH									
									_	∖ ∖YES	□NO	MM DD YY SEX F □								INSI	
b. OTHER INSURED'S DATE OF BIRTH									O ACCII	_	PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME								AND	
MM DD YY SE					SEX	F 🗌		□YES □NO												₹	
C. EMPLOYER'S NAME OR SCHOOL NAME								c. OTH	IER ACC	IDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME									
										YES	□NO									A	
d. INSURANCE PLAN NAME OR PROGRAM NAME									ERVED I	FOR LOCAL US	SE	d. IS THERE ANOTHER NAME OR BENEFIT PLAN?									
												☐YES ☐NO								_	
READ BACK OF FORM BEFORE COMPLE 12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE													INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
SIGNED)								DATE			SIGNED								_ ↓	
									NT HAS	HAD SAME OF MM ; D	R SIMILAR ILLNESS.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM ; DD ; YY MM ; DD ; YY									
MM DD YY INJURY (Accident) OR PREGNANCY (LMP)								GIVE FII	RST DAT		וון שי	FROM TO TY									
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								
19. RESERVED FOR LOCAL USE											20. OUTSIDE LAB? \$ CHARGES										
												YESNO									
21. DIAGNO	SIS OR N	ATURE C)F ILLNE	SS OR I	NJURY,	(RELATE	ITEMS 1, 2,	3 OR 4 TO ITEM 24E BY LINE) —				22. MEDICAID CODE	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.								
1 3.								. L Y				23. PRIOR AUTHORIZATION NUMBER								41	
2. 24 . A	A B C									_	F G H I J						K	— გ			
FRO	DATE(S)	ATE(S) OF SERVICE PLACE TYPE PROCEDU			PROCEDUR	ES, SE	RVICES,	OR SUPPLIES UMSTANCES)	DIAGNOSIS	\$ CHAR	GES						ERVED FC	DR MAT			
MM DI			YY	SERVICE SERVICE CPT/H		CPT/HCPC	PCS MODIFIER		DIFIER	CODE			UNITS PLAN		LIVIO COB		LOCAL USE		~~		
																				N	
2																					
																				SUPPLIER	
3			1					1													
																				1	
4								1												SICIAN	
5								-												PHY	
6			<u> </u>			\Box														_ -	
25. FEDER <i>A</i>	AL TAX I.D	NUMBF	I R	SSN	EIN	26. P	ATIENT'S AC	COUNT	Γ NO.	27. ACC	EPT ASSIGNMENT?	28. TOTAL CH	ARGE	<u> </u> 	29 . AMO	UNT PA	ID.	30 . BAI	ANCE DU	_	
						-5. 7				□ YES	_	\$			\$			\$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE												33. PHYSICIAN				NAME,	ADDRES		ODE	-	
INCLUDING DEGREES OR CREDENTIALS "I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED RENDERED (If other the												& PHONE									
ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED."																					
INDICATED."																					
CICNED												1000									

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

INSURANCE FRAUD STATEMENT

The New York State Department of Insurance requires we notify you that "any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation."