



APPROVED OMB-0938-0008
For services rendered out of area, provider should submit claim to the local Blue Cross and Blue Shield plan.

Important filing instructions on next page

PO BOX 1407, CHURCH STREET STATION
NEW YORK NY 10008-1407
1-800-939-7515



SUFFOLK COUNTY
EMHP
Employee Medical Health Plan of Suffolk County

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY M SEX F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No. Street)
8. PATIENT STATUS
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

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

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES

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

Table with 6 rows and 11 columns: A DATE(S) OF SERVICE, B PLACE OF SERVICE, C TYPE OF SERVICE, D PROCEDURES, SERVICES, OR SUPPLIES, E DIAGNOSIS CODE, F \$ CHARGES, G DAYS OR UNITS, H EPSDT FAMILY PLAN, I EMG, J COB, K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE \$
29. AMOUNT PAID \$
30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER

## 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.