**HEALTH INSURANCE CLAIM FORM**

1. **MEDICARE** | **M EDICARE MEDICAID CHAMPUS CHAMPVA GROUP FECA OTHER**
(Medicare #) | (Medicaid #) | (Sponsor’s SSN) | (VA File #) | (SSN or ID) | (ID)

2. **PATIENT’S I.D. NUMBER (Include prefix)** (FOR PROGRAM IN ITEM 1)

3. **PATIENT’S BIRTH DATE**
   - MM
   - DD
   - YY
   - SEX

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

5. **PATIENT’S ADDRESS (No. Street)**

6. **PATIENT’S BIRTH DATE**

7. **PATIENT’S RELATIONSHIP TO INSURED**
   - Self
   - Spouse
   - Child
   - Other

8. **PATIENT’S ADDRESS (No. Street)**

9. **PATIENT’S BIRTH DATE**

10. **PATIENT’S STATUS**
   - Single
   - Married
   - Other

11. **INSURED’S ADDRESS (No. Street)**

12. **PATIENT’S ACCOUNT NO.**

13. **PHYSICIAN’s SIGNATURE**

14. **DATE AND TIME OF SERVICE**

15. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

16. **PHYSICIAN’s BILLING NAME, ADDRESS, ZIP CODE**

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

18. **DATE(S) OF SERVICE PLACE TYPE PROCEDURES, SERVICES, OR SUPPLIES $ CHARGES**

19. **FEDERAL TAX I.D. NUMBER**

20. **TOTAL CHARGE**

21. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**

22. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
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.

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.”