



GROUP CATASTROPHIC HEALTH INSURANCE CLAIM FORM

INSTRUCTIONS:

- When submitting the first claim for a patient in a benefit period, complete all sections of this form and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- When submitting subsequent claims for a patient in a benefit period, complete all areas of information that have changed since the last claim on this patient. If your address has changed, **CHECK HERE** ☐, and enter the new address in the Member Information Section.

— MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:

AGIA

P.O. BOX 9060

PHOENIX, ARIZONA 85068-9060

1-800-854-8301

CLAIM PROCESSING INFORMATION

▶ MEMBER'S LAST NAME: _____	FIRST NAME: _____	INITIAL: _____	▶ SECURITY NUMBER: _____	▶ YOUR GROUP POLICY NUMBER: G-30104
▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE INSURANCE OR HEALTH BENEFITS? ☐ YES ☐ NO IF YES, INDICATE TYPE BELOW, AND PROVIDE INFORMATION REQUESTED TO THE RIGHT:	OTHER CARRIER'S NAME: _____ ADDRESS: _____ TELEPHONE NUMBER: () - _____ NAME OF COVERED PERSON: _____ PLAN NUMBER: _____		▶ IS CONDITION RELATED TO: PATIENT'S EMPLOYMENT? ☐ YES ☐ NO AN AUTO ACCIDENT? ☐ YES ☐ NO ANY OTHER ACCIDENT? ☐ YES ☐ NO	
☐ HMO ☐ ANOTHER GROUP PLAN ☐ MEDICARE ☐ AUTO INSURANCE ☐ UNION/ASSOCIATION ☐ FEDERAL OR STATE PROGRAM			IF RELATED TO AN ACCIDENT PLEASE INDICATE: WHEN IT HAPPENED: _____ WHERE IT HAPPENED: _____ HOW IT HAPPENED: _____ IS COVERAGE PROVIDED UNDER COBRA? ☐ YES ☐ NO	

MEMBER INFORMATION

▶ STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ DAYTIME TELEPHONE NUMBER: () - _____	▶ NAME OF YOUR EMPLOYER: _____ NAME OF POLICYHOLDER/PLANHOLDER (IF NOT THE SAME AS EMPLOYER): _____ POLICYHOLDER/PLANHOLDER ADDRESS: _____
▶ DATE OF BIRTH: MONTH____ DAY____ YEAR____ ▶ SEX: ☐ MALE ☐ FEMALE	▶ IF NOT ACTIVELY AT WORK, PROVIDE DATE YOU LAST WORKED: MONTH____ DAY____ YEAR____
▶ EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME	REASON: ☐ TERMINATED ☐ RETIRED ☐ DISABLED
▶ DATE EMPLOYED MONTH____ DAY____ YEAR____	☐ LEAVE OF ABSENCE ☐ LAID OFF
▶ MARITAL STATUS: ☐ SINGLE ☐ MARRIED	▶ IF CLAIM INVOLVES DISABILITY, PROVIDE:
☐ WIDOWED ☐ DIVORCED	FIRST FULL DAY OF DISABILITY: MONTH____ DAY____ YEAR____ DATE YOU RETURNED OR EXPECT TO RETURN TO WORK: MONTH____ DAY____ YEAR____

SPOUSE INFORMATION

▶ NAME: _____ (FIRST) (LAST, IF DIFFERENT)	▶ NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SPOUSE'S EMPLOYER: _____
▶ DATE OF BIRTH: MONTH____ DAY____ YEAR____	_____
▶ SOCIAL SECURITY NUMBER: ____/____/____	_____

PATIENT'S INFORMATION (COMPLETE ONLY FOR DEPENDENT CLAIMS)

▶ PATIENT'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____ STREET ADDRESS (IF DIFFERENT FROM EMPLOYEE'S ADDRESS): _____ CITY: _____ STATE: _____ ZIP CODE: _____	▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD MARRIED? ☐ YES ☐ NO EMPLOYED? ☐ YES ☐ NO UNABLE TO WORK DUE TO DISABILITY? ☐ YES ☐ NO COVERED BY ACCIDENT INSURANCE THROUGH SCHOOL? ☐ YES ☐ NO GIVE NAME AND ADDRESS OF CURRENT OF FORMER EMPLOYER OR SCHOOL: _____
▶ PATIENT'S RELATIONSHIP TO EMPLOYEE: ☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER _____	
▶ PATIENT'S SEX: ☐ MALE ☐ FEMALE	▶ IF OVER 18, IS CHILD: DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☐ NO A FULL TIME STUDENT? ☐ YES ☐ NO
▶ DATE OF BIRTH: MONTH____ DAY____ YEAR____	IF YES, GIVE NAME AND ADDRESS OF SCHOOL: _____
▶ SOCIAL SECURITY NUMBER: ____/____/____	_____

MEMBER CERTIFICATION

PLEASE NOTE: ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I CERTIFY THAT THE INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE _____ DATE _____
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

FOR NEW YORK LIFE USE ONLY

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE (COMPLETE ONLY IF BENEFITS ARE TO BE PAID TO THE PROVIDER)

I authorize payment to the physician or supplier for the services specified on the attached itemized bills.

MEMBER'S SIGNATURE

DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT: MO DY YR	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED YOU FOR THIS CONDITION MO DY YR	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO IF YES, GIVE FIRST DATE. MO DY YR				
DATE OF PARTIAL/TOTAL DISABILITY FROM MO DY YR THROUGH MO DY YR	DATE PATIENT ABLE TO RETURN TO WORK MO DY YR	WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO					
DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MO DY YR THROUGH MO DY YR		ARE THE SERVICES RENDERED COVERED BY ANY OTHER GROUP PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING: PLAN NUMBER CARRIER'S NAME AND ADDRESS					
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MO DY YR THROUGH MO DY YR							
NAME OF REFERRING PHYSICIAN							
NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)							
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BOX BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE.							
1. _____ 3. _____ 2. _____ 4. _____							
DATE(S) OF SERVICE FROM MO DY YR THROUGH MO DY YR	PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/MODIFIER	DIAGNOSIS CODE	FULLY DESCRIBE PROCEDURE	DAYS OR UNITS	CHARGES	
FEDERAL TAX I.D. NUMBER	SSN	EIN	PATIENT'S ACCOUNT NO.		TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
	☐	☐			\$	\$	\$
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS					PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		
SIGNED _____ DATE _____							