



# 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: <b>G-30104</b>
▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE INSURANCE OR HEALTH BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, INDICATE TYPE BELOW, AND PROVIDE INFORMATION REQUESTED TO THE RIGHT: <input type="checkbox"/> HMO <input type="checkbox"/> ANOTHER GROUP PLAN <input type="checkbox"/> MEDICARE <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> UNION/ASSOCIATION <input type="checkbox"/> FEDERAL OR STATE PROGRAM	▶ OTHER CARRIER'S NAME: _____ ADDRESS: _____ TELEPHONE NUMBER: ( ) - _____ NAME OF COVERED PERSON: _____ PLAN NUMBER: _____		▶ IS CONDITION RELATED TO: PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO AN AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO ANY OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
			IF RELATED TO AN ACCIDENT PLEASE INDICATE: WHEN IT HAPPENED: _____ WHERE IT HAPPENED: _____ HOW IT HAPPENED: _____ IS COVERAGE PROVIDED UNDER COBRA? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	▶ IF NOT ACTIVELY AT WORK, PROVIDE DATE YOU LAST WORKED: MONTH ___ DAY ___ YEAR ___
▶ EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	REASON: <input type="checkbox"/> TERMINATED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> LEAVE OF ABSENCE <input type="checkbox"/> LAID OFF
▶ DATE EMPLOYED MONTH ___ DAY ___ YEAR ___	▶ IF CLAIM INVOLVES DISABILITY, PROVIDE: FIRST FULL DAY OF DISABILITY: MONTH ___ DAY ___ YEAR ___ DATE YOU RETURNED OR EXPECT TO RETURN TO WORK: MONTH ___ DAY ___ YEAR ___
▶ MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	

### 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: _____	▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO
STREET ADDRESS (IF DIFFERENT FROM EMPLOYEE'S ADDRESS): _____	EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CITY: _____ STATE: _____ ZIP CODE: _____	UNABLE TO WORK DUE TO DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
▶ PATIENT'S RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER _____	COVERED BY ACCIDENT INSURANCE THROUGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO GIVE NAME AND ADDRESS OF CURRENT OF FORMER EMPLOYER OR SCHOOL: _____
▶ PATIENT'S SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	▶ IF OVER 18, IS CHILD: DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MO   DY   YR THROUGH MO   DY   YR		IF YES, COMPLETE THE FOLLOWING: PLAN NUMBER _____	
NAME OF REFERRING PHYSICIAN		CARRIER'S NAME AND ADDRESS _____ _____ _____	
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 THROUGH MO DY YR 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 <input type="checkbox"/>	EIN <input type="checkbox"/>	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 _____						