



# GROUP HEALTH INSURANCE CLAIM FORM

## INSTRUCTIONS:

- When submitting the first claim for a patient in a calendar year, 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 calendar year, complete all areas where information has 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:

Group Insurance Program  
P.O. Box 9060  
Phoenix, AZ 85068-9060

## CLAIM PROCESSING INFORMATION

▶ MEMBER'S LAST NAME: _____	FIRST NAME: _____	INITIAL: _____	▶ SECURITY NUMBER: _____	▶ YOUR GROUP POLICY NUMBER: _____
▶ 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: _____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO UNABLE TO WORK DUE TO DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER _____	
▶ 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 IF YES, GIVE NAME AND ADDRESS OF SCHOOL: _____
▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___	
▶ SOCIAL SECURITY NUMBER: _____	

## MEMBER CERTIFICATION

PLEASE NOTE: ANY PERSON WHO KNOWINGLY AND WITH THE 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 SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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, my employer or other representatives any information, including medical, employment and benefit information required for claim processing or plan administration.*

*This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand 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 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 <input type="checkbox"/>	EIN <input type="checkbox"/>	PATIENT'S ACCOUNT NO.	TOTAL CHARGES \$	AMOUNT PAID \$	BALANCE DUE \$
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SIGNATURE OF PHYSICIAN OR SUPPLIER  
INCLUDING DEGREES OR CREDENTIALS

PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE  
& PHONE #

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_