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 INURANCE PROGRAM
ALLIED BENEFIT SYSTEMS, INC
PO BOX 909786-60690
CHICAGO, IL 60690
(800) 337-3104

CLAIM PROCESSING INFORMATION

▶ MEMBER'S LAST NAME: FIRST NAME: INITIAL:

▶ SECURITY NUMBER: ___/__/____

▶ YOUR GROUP POLICY NUMBER: G29065

▶ 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:

- ❑ HMO
- ❑ ANOTHER GROUP PLAN
- ❑ MEDICARE
- ❑ AUTO INSURANCE
- ❑ UNION/ASSOCIATION
- ❑ FEDERAL OR STATE PROGRAM

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

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: (   )   –

▶ DATE OF BIRTH: MONTH____ DAY___ YEAR___ ▶ SEX: ❑ MALE ❑ FEMALE

▶ EMPLOYMENT STATUS ❑ FULL-TIME ❑ PART-TIME

▶ DATE EMPLOYED MONTH____ DAY____ YEAR____

▶ MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

▶ NAME OF YOUR EMPLOYER:

NAME OF POLICYHOLDER/PLANHOLDER (IF NOT THE SAME AS EMPLOYER):

POLICYHOLDER/PLANHOLDER ADDRESS:

▶ IF NOT ACTIVELY AT WORK, PROVIDE DATE YOU LAST WORKED:
MONTH____ DAY____ YEAR____
REASON: ❑ TERMINATED ❑ RETIRED ❑ DISABLED ❑ LEAVE OF ABSENCE ❑ LAID OFF

▶ 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____

SPOUSE INFORMATION

▶ NAME: ____ (FIRST) (LAST, IF DIFFERENT)

▶ DATE OF BIRTH: MONTH____ DAY____ YEAR____

▶ SOCIAL SECURITY NUMBER: ___/__/____

▶ NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SPOUSE'S EMPLOYER:

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:

▶ PATIENT'S RELATIONSHIP TO EMPLOYEE: ❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ OTHER ____

▶ PATIENT'S SEX: ❑ MALE ❑ FEMALE

▶ DATE OF BIRTH: MONTH____ DAY____ YEAR____

▶ SOCIAL SECURITY NUMBER: ___/__/____

▶ 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:

▶ IF OVER 18, IS CHILD: DEPENDENT UPON YOU FOR SUPPORT? ❑ YES ❑ NO
A FULL TIME STUDENT? ❑ YES ❑ NO
IF YES, GIVE NAME AND ADDRESS OF SCHOOL:

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 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

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)*

ARE THE SERVICES RENDERED COVERED BY ANY OTHER GROUP PLAN? ❑ YES ❑ NO

IF YES, COMPLETE THE FOLLOWING:

PLAN NUMBER ______________

CARRIER'S NAME AND ADDRESS ______________________

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. ______________________
2. ______________________
3. ______________________
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

SIGNED ______________________ DATE ______________

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