[redacted]

PLEASE DO NOT STAPLE IN THIS AREA

EMPIRE BLUECROSS BLUESHIELD

DO NOT WRITE IN THIS AREA

MAIL CLAIM FORM TO: **BELL ATLANTIC**
DEDICATED SERVICE CENTER
PO BOX 5047, MIDDLETOWN NY 10940-9047
TELEPHONE NO. **(800) 635-2184**

MEDICAL PLAN CLAIM FORM

FOR ACTIVE AND RETIRED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS.
PLEASE READ INSTRUCTIONS ON SIDE TWO BEFORE COMPLETING THIS FORM.

SECTION I - EMPLOYEE/PATIENT INFORMATION

1. EMPLOYEE SOCIAL SECURITY NUMBER **NYN**

2. EMPLOYEE FIRST NAME | MIDDLE INITIAL | LAST NAME

3. EMPLOYEE HOME ADDRESS | CITY | STATE | ZIP CODE

4. EMPLOYEE HOME TELEPHONE NO.

3A. TEMPORARY MAILING ADDRESS | CITY | STATE | ZIP CODE

4A. WORK TELEPHONE NO.

5. PATIENT FIRST NAME | MIDDLE INITIAL | LAST NAME

6. PATIENT DATE OF BIRTH

7. PATIENT SEX ❒ MALE ❒ FEMALE

8. PATIENT RELATIONSHIP TO EMPLOYEE:
❒ SELF ❒ SPOUSE ❒ DEPENDENT CHILD ❒ CLASS TWO ❒ SURVIVING SPOUSE ❒ SPONSORED CHILD ❒ HANDICAPPED DEPENDENT

9. IS PATIENT A FULL-TIME STUDENT? ❒ YES ❒ NO

9A. IF YES, GIVE NAME OF SCHOOL AND ADDRESS

9B. STUDENT SOCIAL SECURITY NO.

10. IS THE ILLNESS OR INJURY EMPLOYMENT RELATED (WORKERS' COMPENSATION)? ❒ YES ❒ NO

11. IS THE ILLNESS OR INJURY RELATED TO AN AUTOMOBILE ACCIDENT? ❒ YES ❒ NO

12. IS PATIENT MEDICARE ELIGIBLE? ❒ YES ❒ NO

12A. MEDICARE IDENTIFICATION NO.

12B. MEDICARE EFFECTIVE DATE

13. PAY TO: ■ PROVIDER ■ EMPLOYEE

14. DOES PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ❒ YES ❒ NO IF YES, PLEASE GIVE THE INSURANCE COMPANY NAME, ADDRESS AND THE POLICY NUMBER, AND ATTACH YOUR OTHER COVERAGE EXPLANATION OF BENEFITS.

15. **CERTIFICATION AND AUTHORIZATION.** I hereby authorize the release of any information to Empire Blue Cross and Blue Shield acquired in the course of my examination or treatment. I certify that the information provided by me in support of this claim is complete and correct and that I have not previously filed a claim for reimbursement of these services.

Signature of employee or authorized legal representative: ➤ **Date Signed:**

SECTION II - PHYSICIAN OR SUPPLIER INFORMATION (Fill out this section completely or attach itemized bills for services rendered)

16. DATE OF ONSET OF CONDITION

17. DATE FIRST CONSULTED FOR CONDITION

18. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ❒ YES ❒ NO

19. EMERGENCY RELATED? ❒ YES ❒ NO

20. FOR SERVICES RELATED TO A HOSPITALIZATION INDICATE FACILITY NAME:

20A. FACILITY ADDRESS

20B. ADMISSION DATE

20C. DISCHARGE DATE

20D. SURGERY DATE

20E. TYPE OF SURGERY

21. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 22D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE.

1.
2.
3.

22. DATE OF SERVICE	22A. PLACE *	22B. SOURCE CODE ➤ PROCEDURE CODE (CPT-4)	MOD	MOD	22C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (*EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES*)	22D. SOURCE CODE ➤ DIAGNOSIS CODE (ICD-9)	22E. DAYS OR UNITS	22F. CHARGES
						•		
						•		
						•		
						•		
						•		

23. PATIENT ACCOUNT NUMBER

24. TOTAL CHARGE

25. AMOUNT PAID

26. BALANCE DUE

27. PROVIDER TAX IDENTIFICATION NUMBER

28. PHYSICIAN OR SUPPLIER NAME, ADDRESS AND ZIP CODE

29. I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THE FACE OF THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT FOR THE CHARGES ENTERED IN COLUMN

SIGNATURE OF PHYSICIAN OR SUPPLIER: ➤ **DATE SIGNED:**

TELEPHONE NUMBER ( ) EXTENSION

SEE CODES ON SIDE TWO IN SECTION II

SIDE ONE

An independent member of the Blue Cross and Blue Shield Association