

PO Box 1407, Church Street Station New York, NY 10008-1407

PICA		HEALTH INSU	RANCE CLAIM FO	RM	PICA TTT	
1. MEDICARE MEDICAID CHAMPUS	CHAMPVA GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER	(FOR PF	ROGRAM IN ITEM 1)	
(Medicare #) (Medicaid #) (Sponsor's SSN)	(VA File #) HEALTH PLAN	BLK LUNG (SSN) (ID)			17	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIO	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)				
	Self Spouse	Self Spouse Child Other				
CITY	STATE 8. PATIENT STATUS Single 1	Married Other	CITY		STATE	
ZIP CODE TELEPHONE (Include Area			ZIP CODE	TELEPHONE (Include	Area Code)	
		ull-Time Part-Time Student	Part-Time Student		١٥	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle	Initial) 10. IS PATIENT'S CO	10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER		6		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (a. EMPLOYMENT? (Current or Previous)		I * ~		
	☐ YE	s 🗆 NO	MM DD '	ΥΥ	SEX F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX	b. AUTO ACCIDENT	? PLACE (State)	b. EMPLOYER'S NAME OR S	CHOOL NAME		
M F	YE:	S NO				
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT	OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME TYES NO		DATIE		
d. INSURANCE PLAN NAME OR PROGRAM NAME	لــــــــــــــــــــــــــــــــــــ		d. IS THERE ANOTHER NAME OR BENEFIT PLAN?			
				YES NO		
READ BACK OF FORM BEF 12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRI	FORE COMPLETING THIS FORM. IBED ON THE REVERSE SIDE OF THI	IS CLAIM FORM.	13. INSURED'S OR AUTHORI of medical benefits to the described below.	ZED PERSON'S SIGNATURE ne undersigned physician o	I authorize payment or supplier for services	
			described selecti			
SIGNED DATE			SIGNED			
14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR PREGNANCY (LMP)		SAME OR SIMILAR ILLNESS. MM DD YY	16. DATES PATIENT UNABLE MM DD Y FROM	TO WORK IN CURRENT O	CCUPATION DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REI	FERRING PHYSICIAN	18. HOSPITALIZATION DATE:		ERVICES DD YY	
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB?	\$ CHARGES		
13. RESERVED FOR EGGAL GSE			YES NO		1 []	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSIO			
1. L	3	₩	CODE	ORIGINAL REF. NO.		
J			23. PRIOR AUTHORIZATION NUMBER			
2. L 24. A B C	4	E	F G	H I J	K 2	
DATE(S) OF SERVICE PLACE TYPE FROM TO OF OF	PROCEDURES, SERVICES, OR S	UPPLIES	DA	YS EPSDT R FAMILY EMG COB	RESERVED FOR	
MM DD YY MM DD YY SERVICE SERVICI				ITS PLAN	LOCAL USE	
					2	
3					Idalis	
4						
					NACION	
5					À	
6						
25. FEDERAL TAX I.D. NUMBER SSN EIN 26.	PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE	
25. I EDERME IMA I.D. NOIVIDER SON EIN 26.	PATIENT 3 ACCOUNT NO.		l. :		1.	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND ADDRESS OF FA			\$ \$ \$ \$ \$ \$ 33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE			
INCLUDING DEGREES OR CREDENTIALS "I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED	RENDERED (If other than home o		& PHONE NUMBER			
ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED."						
SIGNED DATE			PIN#	GRP#		

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire BlueCross BlueShield or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any health care provider, payor of health claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

INSURANCE FRAUD STATEMENT

The New York State Department of Insurance requires we notify you that "any person who knowingly and 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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation."