

Patient's Statement

CLAIM FORM FOR PHYSICIAN SERVICES

INSTRUCTIONS: This side of the form is to be filled out by you. Then send the form to the physician, so that he or she can fill out the reverse side and return it to us.

- **HIP VIP:** Do NOT file claim with Medicare; follow above instructions
- **MEDICARE MEMBERS:** Explanation of Medicare Benefits statement must accompany this form.

All questions must be complete. Incomplete forms will be returned.

HIP No. (Patient)		1. INSURED'S HIP NUMBER	
2. PATIENT'S NAME (Last Name, First Name, Middle initial)		2. PATIENT'S BIRTH DATE MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No. Street)		4. INSURED'S NAME (Last Name, First Name, Middle initial)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		2. INSURED'S ADDRESS (No. Street)	
CITY	STATE	8. PATIENT STATUS	
ZIP CODE	TELEPHONE (Include Area Code) ()	Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		Employed <input type="checkbox"/> Full time Student <input type="checkbox"/> Part time Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		8. IS PATIENT'S CONDITION RELATED TO:	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		a. EMPLOYMENT? (CURRENT OR PREVIOUS) Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. AUTO ACCIDENT? PLACE (State) Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		11. INSURED'S POLICY NUMBER	
		a. INSURED'S DATE OF BIRTH MM DD YY	
		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes return to and complete item 9 a-d	

12. Please describe the circumstance that made it necessary for you to receive the medical care for which you are claiming benefits.

13. I hereby authorize and direct any Physician, Hospital or Medical provider who rendered service to me for any illness or injury, to release to the Health Insurance Plan of Greater New York any information acquired during the course of such examination or treatment. I also consent to the disclosure of this claim to the medical provider by the Health Insurance Plan of Greater New York of anything related to my claim.

A photocopy of this authorization will be valid as the original.

Signature of Patient or authorized agent _____ Date _____

14. I authorize payment directly to the physician who signed the reverse side of this claim form.

Signature of Patient or authorized agent _____ Date _____



Physician's Statement

Place of Service Codes:

- 11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Center
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance - Air or Water
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility
00 Other Vehicle

Type of Service Codes:

- 1 Primary Surgery
2 Assistant Surgery
3 Single Patient in Nursing Home/SNF
4 Anesthesia
5 Radiology
6 In Hospital Medical Care
7 Medical Care
8 Pathology
9 Outpatient Consultation
0 Medical Diagnostic Testing
10 Emergency Care
12 Hospice
14 Dental
16 Physical Therapy
18 Speech Therapy
20 Occupational Therapy
22 Home Health Care
24 Nursing
26 Termination of Pregnancy
28 Psychiatric Care
30 Alcohol Detox
32 Alcohol Rehab
34 Drug Detox
36 Drug Rehab
38 Dialysis
40 Transportation
42 Optical
A Ambulance
B Drugs and Biologicals
C Blood
D Professional Component
E Physician Assistant, In Hospital Care
F Physician Assistant, Other than Hospital Care
G Physician Asst Assist at Surgery
H Home Consultation
K Office Consultation
M ME Maintenance
N Wholesale Supplies, Nursing Home
P ME Purchase, New Equipment
R ME Rental
S Supplies
T Technical Component
U ME Purchase, Used Equipment
W Hospital Consultation
Z Ambulatory Surgery

Form containing patient information (HIP No., Name, Birth Date, Sex), diagnosis details, and billing information (Charges, Amount Paid, Balance Due). Includes a table for medical services with columns for Date of Service, Place of Service, Type of Service, Procedures, Diagnosis Code, and Charges.