Health Benefit Claim Form

Please complete and return to:
Health Republic Insurance of NY
P.O. Box 6329
Syracuse, NY 13206
www.newyork.healthrepublic.us

HEALTH REPUBLIC
INSURANCE

Section 1. Enrollee/Employee Information.			
Member Identification Number:		Phone Number:	
Last Name:	First Name:	Middle Initial:	Date of Birth:
Address:		New Address: ☐ Yes ☐ No	
City:	State:	Zip Code:	
Employer Name:		Plan Number (located on your POMCO Group ID card):	
Spouse Last Name:	Spouse First Name:	Middle Initial:	Spouse Date of Birth:

Section 2. Patient Information.			
Last Name:	First Name:	Middle Initial:	Date of Birth:
Address: ☐ Check if same as enrollee	City:	State:	Zip Code:
Relationship to Subscriber:	Full-Time Student: ☐ Yes ☐ No	School Name:	School Phone Number:

Section 3. Accident Information.		
Workplace Accident: ☐ Yes ☐ No	Auto Accident: ☐ Yes ☐ No	Date Accident Occurred:
How did the accident occur?		

Section 4. Additional Health Coverage Information.	
Is the patient covered by another insurance plan? ☐ Yes ☐ No If yes, please complete the following:	
Name of person carrying other insurance:	Date of Birth:
Identification Number:	Name of Other Carrier:
Policy Number:	Employer Name:

Section 5. Acknowledgement. My signature authorizes the release of my information or the information of my minor child under the age of 18 years old only. Any person who knowingly and with intent to defraud any health plan files any materially false information, or conceals for the purpose of misleading, may be committing a crime and may be subject to a civil penalty for each violation. I certify that the above information is true to the best of my knowledge. In addition, my signature authorizes any physician or hospital to provide pertinent records to Health Republic Insurance of NY, upon request including records for any illness or condition needed (including mental illness and/or AIDS/HIV) to evaluate claims.

Signature:	Date:

Section 6. Assignment of Benefits. Please sign below only if you want Health Republic of NY to pay benefits directly to the provider of medical services. You must authorize the release of your own information unless you are under the age of 18 or of diminished capacity. If this is the case, your parent, guardian or spouse must sign.

Enrollee Signature:	Date:

Section 7. Claims Submission Guidelines.

- Clip, do not staple, all original itemized bills to this completed form and mail them to Health Republic of NY
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to Health Republic of NY in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your member identification number on all documents.

How to File a Medical Claim with
Health Republic Insurance of NY

You may submit Medical Claims by mailing a claim request, faxing a claim request or by e-mailing a claim request. Please follow the instructions below to submit a Medical Claim:

To mail a Medical Claim:

1. Complete a paper form
2. Gather all receipts for qualified expenses
3. Mail all to:
   Health Republic Insurance of NY
   P.O. Box 6329
   Syracuse, NY 13206

To fax a Medical Claim:

1. Complete a paper form
2. Gather all receipts for qualified expenses
3. Fax all to: 315.432.9442

To e-mail a Medical Claim:

1. Complete a paper form
2. Gather all receipts for qualified expenses
3. E-Mail all to: **HRINYclaims@pomcogroup.com**

- Clip, do not staple, all original itemized bills to the completed claim form and send them to Health Republic of NY
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to Health Republic of NY in a timely manner.
- Please include your member identification number on all documents.