HIP

HEALTH PLAN OF NEW YORK
7 WEST 34TH STREET • NEW YORK, NEW YORK 10001

DOC No. (To be entered by HIP)

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

IMPORTANT: The reverse side is to be filled out by the physician

HIP

HEALTH PLAN OF NEW YORK
7 WEST 34TH STREET • NEW YORK, NEW YORK 10001

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 DME Maintenance
N Wholesale Supplies, Nursing Home
P DME Purchase, New Equipment
R DME Rental
S Supplies
T Technical Component
U DME Purchase, Used Equipment
W Hospital Consultation
Z Ambulatory Surgery

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 ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle initial)

5. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

6. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

7. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

8. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

9. LICENSE/UPN # OF REFERRING PHYSICIAN

10. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 5,6,7 OR 8 TO ITEM 14E BY LINE →

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

12.. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

13. PRIOR AUTHORIZATION NUMBER

14 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	14 B Place of Service	14 C Type of Service	14 D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	14 E DIAGNOSIS CODE	14 F $ CHARGES	14 G - MEDICAL SERVICES Fully Describe Procedures

15. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

16. PATIENT'S ACCOUNT NO.

17. ACCEPT ASSIGNMENT. YES ☐ NO ☐

18. TOTAL CHARGES $

19. AMOUNT PAID $

20. BALANCE DUE $

21. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill are made a part thereof).

SIGNED DATE

22. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).

23. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS ZIP, CODE & PHONE NUMBER.

LICENSE # GRP#

PLEASE PRINT OR TYPE