



GROUP HEALTH INSURANCE CLAIM FORM



MAIL COMPLETED FORM AND ANY ITEMIZED BILLS TO:

ASCE GROUP INSURANCE
P.O. BOX 2947
COVINGTON, LA 70434
(800) 650 - 2723

INSTRUCTIONS:

- When submitting the first claim for a patient in a calendar year, complete all sections of this form and sign the Member Certification. **COMPLETION** of the entire form speeds claims processing.
- When submitting subsequent claims for a patient in a calendar year, complete all areas of information that have changed since the last claim on this patient. If your address has changed, **CHECK HERE** , and enter the new address in the Member Information Section.

CLAIM PROCESSING INFORMATION

▶ MEMBER'S LAST NAME: _____	FIRST NAME: _____	INITIAL: _____	▶ SECURITY NUMBER: _____	▶ YOUR GROUP POLICY NUMBER: _____
▶ ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE INSURANCE OR HEALTH BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, INDICATE TYPE BELOW, AND PROVIDE INFORMATION REQUESTED TO THE RIGHT: <input type="checkbox"/> HMO <input type="checkbox"/> ANOTHER GROUP PLAN <input type="checkbox"/> MEDICARE <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> UNION/ASSOCIATION <input type="checkbox"/> FEDERAL OR STATE PROGRAM	OTHER CARRIER'S NAME: _____ ADDRESS: _____ TELEPHONE NUMBER: () - _____ NAME OF COVERED PERSON: _____ PLAN NUMBER: _____		▶ _____ ▶ IS CONDITION RELATED TO: PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO AN AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO ANY OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF RELATED TO AN ACCIDENT PLEASE INDICATE: WHEN IT HAPPENED: _____ WHERE IT HAPPENED: _____ HOW IT HAPPENED: _____ IS COVERAGE PROVIDED UNDER COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO	

MEMBER INFORMATION

▶ STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ DAYTIME TELEPHONE NUMBER: () - _____	▶ NAME OF YOUR EMPLOYER: _____ NAME OF POLICYHOLDER/PLANHOLDER (IF NOT THE SAME AS EMPLOYER): _____ POLICYHOLDER/PLANHOLDER ADDRESS: _____
▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ ▶ SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ▶ EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME ▶ DATE EMPLOYED MONTH ___ DAY ___ YEAR ___ ▶ MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	▶ IF NOT ACTIVELY AT WORK, PROVIDE DATE YOU LAST WORKED: MONTH ___ DAY ___ YEAR ___ REASON: <input type="checkbox"/> TERMINATED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> LEAVE OF ABSENCE <input type="checkbox"/> LAID OFF ▶ IF CLAIM INVOLVES DISABILITY, PROVIDE: FIRST FULL DAY OF DISABILITY: MONTH ___ DAY ___ YEAR ___ DATE YOU RETURNED OR EXPECT TO RETURN TO WORK: MONTH ___ DAY ___ YEAR ___

SPOUSE INFORMATION

▶ NAME: _____ (FIRST) _____ (LAST, IF DIFFERENT) ▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ ▶ SOCIAL SECURITY NUMBER: _____	▶ NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SPOUSE'S EMPLOYER: _____ _____ _____
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PATIENT'S INFORMATION (COMPLETE ONLY FOR DEPENDENT CLAIMS)

▶ PATIENT'S LAST NAME: _____ FIRST NAME: _____ INITIAL: _____ STREET ADDRESS (IF DIFFERENT FROM EMPLOYEE'S ADDRESS): _____ CITY: _____ STATE: _____ ZIP CODE: _____ ▶ PATIENT'S RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER _____ ▶ PATIENT'S SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ▶ DATE OF BIRTH: MONTH ___ DAY ___ YEAR ___ ▶ SOCIAL SECURITY NUMBER: _____	▶ IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO UNABLE TO WORK DUE TO DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO COVERED BY ACCIDENT INSURANCE THROUGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO GIVE NAME AND ADDRESS OF CURRENT OF FORMER EMPLOYER OR SCHOOL: _____ ▶ IF OVER 18, IS CHILD: DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS OF SCHOOL: _____ _____
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MEMBER CERTIFICATION

PLEASE NOTE: ANY PERSON WHO WITH INTENT TO DEFAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I CERTIFY THAT THE INFORMATION SHOWN ABOVE IS COMPLETE AND ACCURATE.

MEMBER'S SIGNATURE _____ DATE _____
(SIGNATURE OF DEPENDENT SPOUSE IS NOT ACCEPTABLE)

FOR NEW YORK LIFE USE ONLY

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations.

I authorize release to New York Life Insurance Company and any independent claim administrators, consulting health professionals and utilization review organizations with whom New York Life has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits.

This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person has already disclosed or collected information or taken other action in reliance on it. The information New York Life obtains through this authorization may become subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

A photocopy of this authorization and request form shall be as valid as the original. I know that I may request a copy of this authorization.

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE (COMPLETE ONLY IF BENEFITS ARE TO BE PAID TO THE PROVIDER)

I authorize payment to the physician or supplier for the services specified on the attached itemized bills.

MEMBER'S SIGNATURE

DATE

PHYSICIAN OR SUPPLIER INFORMATION (MUST BE COMPLETED IN FULL BY PROVIDER OF SERVICE)

DATE OF CURRENT: MO DY YR	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED YOU FOR THIS CONDITION MO DY YR	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE FIRST DATE. MO DY YR
DATE OF PARTIAL/TOTAL DISABILITY FROM MO DY YR THROUGH MO DY YR	DATE PATIENT ABLE TO RETURN TO WORK MO DY YR	WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MO DY YR THROUGH MO DY YR		ARE THE SERVICES RENDERED COVERED BY ANY OTHER GROUP PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MO DY YR THROUGH MO DY YR		IF YES, COMPLETE THE FOLLOWING: PLAN NUMBER _____	
NAME OF REFERRING PHYSICIAN		CARRIER'S NAME AND ADDRESS _____ _____	
NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED <i>(If other than home or office)</i>		_____ _____	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BOX BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE.			
1. _____		3. _____	
2. _____		4. _____	

DATE(S) OF SERVICE FROM THROUGH MO DY YR MO DY YR	PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/MODIFIER	DIAGNOSIS CODE	FULLY DESCRIBE PROCEDURE	DAYS OR UNITS	CHARGES

FEDERAL TAX I.D. NUMBER	SSN <input type="checkbox"/>	EIN <input type="checkbox"/>	PATIENT'S ACCOUNT NO.	TOTAL CHARGES \$	AMOUNT PAID \$	BALANCE DUE \$
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS				PHYSICIAN'S OR SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		
SIGNED _____ DATE _____						

IMPORTANT NOTICE

Whenever a claim form is given to an Insured who lives in any of the states listed below, this "Important Notice" must be attached to the claim form.

FOR ALASKA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be prosecuted under state law."

FOR ARIZONA RESIDENTS

"For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties."

FOR ARKANSAS RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR CALIFORNIA RESIDENTS "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

FOR COLORADO RESIDENTS

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a claimant for the purpose of defrauding or attempting to defraud the claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

FOR DELAWARE RESIDENTS

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR DISTRICT OF COLUMBIA RESIDENTS

"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FOR FLORIDA RESIDENTS

"Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree in Florida."

FOR HAWAII RESIDENTS

"For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

FOR IDAHO RESIDENTS

"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

FOR INDIANA RESIDENTS

"A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony."

FOR KENTUCKY RESIDENTS

"Any person who knowingly, and with intent to defraud any insurance company or other person files a 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."

FOR LOUISIANA RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

FOR MAINE RESIDENTS

"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits."

FOR MARYLAND RESIDENTS “Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

FOR MINNESOTA RESIDENTS

“Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”

FOR NEW HAMPSHIRE RESIDENTS

“Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.”

FOR NEW JERSEY RESIDENTS

“Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties in New Jersey.”

FOR NEW MEXICO RESIDENTS

“ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.”

FOR NEW YORK RESIDENTS

“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 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 five thousand dollars and the stated value of the claim for each such violation.”

FOR OHIO RESIDENTS

“Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deception statement is guilty of insurance fraud.”

FOR OKLAHOMA RESIDENTS

WARNING: “Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.”

FOR OREGON RESIDENTS

“Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information, or conceals, for purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud and may be subject to prosecution for insurance fraud.”

FOR PENNSYLVANIA RESIDENTS

“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 subjects such person to criminal and civil penalties.”

FOR PUERTO RICO RESIDENTS

“Any person who, knowingly, and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with the fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.”

FOR TENNESSEE RESIDENTS

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

FOR TEXAS RESIDENTS

“Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”

FOR VERMONT RESIDENTS

“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.”

FOR VIRGINIA RESIDENTS

“It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.”