

CLAIM FORM

INSTRUCTIONS:

1. Complete this form and be sure to sign it. A separate claim information form must be completed for each family member for whom a claim is being made.
2. For physician office visit claims, be sure to have your provider complete a CMS 1500 claim form, include your fully itemized bill, proof of payment (credit card receipt, both sides of your cancelled check, or a receipt from your physician's office), and attach all the above information to this form.

Send all claim information to:
Neighborhood Health Partnership, Inc.

UHCRV NHP:
PO Box 5210
Kingston, NY 12402-5210

NOTICE:

Medical benefits are paid directly to the provider (the doctor, hospital) unless you request us to pay otherwise. However if an assignment of benefits has been made to the provider, we will not pay benefits to you unless you provide a CMS 1500 claim form completed by the provider and original bills reflecting that you have made payment in full.

For medical bills submitted, please complete the questions below and enclose your fully itemized bills for processing. To expedite your claims, please submit your bills as they are incurred. Make a copy to keep for your records.

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

1. Employee's Name _____ 2. Employee's ID # _____
3. Group # _____ 4. Employee's Phone # _____
5. Employee's Address _____
6. Patient's Name _____ 7. Patient's ID # _____
8. Is claim due to an accidental injury? Yes No
If yes, what happened? _____
When and where did the accident occur? _____
Did accident/injury occur in the course of employment? Yes No
Was this a motor vehicle accident? Yes No
9. Do you or any of your other dependents have other insurance? Yes No
If yes, name of person(s) insured _____
If yes, name of other insurance company _____
Address of other insurance company _____
10. If a motor vehicle accident, name of auto insurance company and policy number _____
11. Name of spouse's employer _____
Address of spouse's employer _____ Phone # _____
Spouse's employer's insurance company _____ Policy # _____

PROVIDER INFORMATION:

Provider's Name _____ Provider's Telephone # _____
 Provider's Address _____
 Provider's Specialty _____ Provider's Taxpayer ID# (TIN) (_____ - _____)
 Provider's Social Security # (_____ - _____ - _____) Provider's UPIN # (_____)

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or medically related facility, consumer reporting agency, insurance or reinsuring company, or employer to give to Neighborhood Health Partnership (NHP) or their legal representatives, any information required to process my claim. This authorization includes information about: (1) drugs, (2) alcoholism, or (3) mental illness. **I ALSO AUTHORIZE NHP** to release any information obtained to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this authorization. **I AGREE** that a photographic copy of this authorization shall be valid, same as the original.

SIGNATURE of patient _____ Date _____
(Patient's or Authorized Person's Signature)

