



# GROUP HEALTH INSURANCE CLAIM FORM

## 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 where information has 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.

— MAIL COMPLETED FORM AND HOSPITAL BILL TO:  
**ISI INSURANCE TRUST  
 MEDICAL CLAIMS  
 PO BOX 539508  
 GRAND PRAIRIE, TX 75053  
 (866) 755-4532**

## CLAIM PROCESSING INFORMATION

MEMBER'S LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ INITIAL: \_\_\_\_\_

SECURITY NUMBER: \_\_\_\_\_ YOUR GROUP POLICY NUMBER: **G-29050**

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLANS WHICH PROVIDE INSURANCE OR HEALTH BENEFITS?  
 YES  NO IF YES, INDICATE TYPE BELOW, AND PROVIDE INFORMATION REQUESTED TO THE RIGHT:

OTHER CARRIER'S NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE NUMBER: \_\_\_\_\_  
 ( ) - \_\_\_\_\_  
 NAME OF COVERED PERSON: \_\_\_\_\_  
 PLAN NUMBER: \_\_\_\_\_

IS CONDITION RELATED TO: PATIENT'S EMPLOYMENT?  YES  NO  
 AN AUTO ACCIDENT?  YES  NO  
 ANY OTHER ACCIDENT?  YES  NO

IF RELATED TO AN ACCIDENT PLEASE INDICATE:  
 WHEN IT HAPPENED: \_\_\_\_\_  
 WHERE IT HAPPENED: \_\_\_\_\_  
 HOW IT HAPPENED: \_\_\_\_\_

IS COVERAGE PROVIDED UNDER COBRA?  YES  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:  MALE  FEMALE  
 EMPLOYMENT STATUS  FULL-TIME  PART-TIME  
 DATE EMPLOYED MONTH \_\_\_ DAY \_\_\_ YEAR \_\_\_  
 MARITAL STATUS:  SINGLE  MARRIED  
 WIDOWED  DIVORCED

IF NOT ACTIVELY AT WORK, PROVIDE DATE YOU LAST WORKED:  
 MONTH \_\_\_ DAY \_\_\_ YEAR \_\_\_  
 REASON:  TERMINATED  RETIRED  DISABLED  
 LEAVE OF ABSENCE  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:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 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:  SPOUSE  CHILD  STEPCHILD  
 OTHER \_\_\_\_\_

PATIENT'S SEX:  MALE  FEMALE  
 DATE OF BIRTH: MONTH \_\_\_ DAY \_\_\_ YEAR \_\_\_  
 SOCIAL SECURITY NUMBER: \_\_\_\_\_

IF CLAIM IS FOR DEPENDENT CHILD, WHEN CHARGES WERE INCURRED, WAS CHILD MARRIED?  YES  NO  
 EMPLOYED?  YES  NO  
 UNABLE TO WORK DUE TO DISABILITY?  YES  NO  
 COVERED BY ACCIDENT INSURANCE THROUGH SCHOOL?  YES  NO  
 GIVE NAME AND ADDRESS OF CURRENT OF FORMER EMPLOYER OR SCHOOL:  
 \_\_\_\_\_

IF OVER 18, IS CHILD: DEPENDENT UPON YOU FOR SUPPORT?  YES  NO  
 A FULL TIME STUDENT?  YES  NO  
 IF YES, GIVE NAME AND ADDRESS OF SCHOOL:  
 \_\_\_\_\_

## MEMBER CERTIFICATION

PLEASE NOTE: ANY PERSON WHO KNOWINGLY AND WITH THE 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 SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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, my employer or other representatives any information, including medical, employment and benefit information required for claim processing or plan administration.

This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand 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 IF YES, COMPLETE THE FOLLOWING: PLAN NUMBER _____
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MO DY YR THROUGH MO DY YR			CARRIER'S NAME AND ADDRESS _____ _____ _____
NAME OF REFERRING PHYSICIAN			
NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			

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 _____						