



New York State Government Employees Health Insurance Program

HEALTH INSURANCE CLAIM FORM

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Form with 33 numbered sections for patient and insured information, physician details, and charges. Includes fields for name, address, birth date, insurance policy number, and signature.

PLEASE ASK PROVIDER TO TYPE THIS FORM

**INSURANCE FRAUDS PREVENTION ACT**

The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department:

"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, 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."

**PLEASE MAIL CLAIMS TO:** United HealthCare Insurance Company of New York  
P.O. Box 1600  
Kingston, New York 12402-1600  
1-800-942-4640