NON-PARTICIPATING PROVIDER CLAIM FORM

Vytra HEALTH PLANS
PO Box 9091, Melville, NY 11747-9091 • 516-694-4000

PATIENT / INSURED TO COMPLETE TOP PORTION (1-13)

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)		1a. INSURED I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. 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'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S NAME AND ADDRESS (No. Street)
CITY STATE	8. PATIENT'S STATUS Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )	Employed ☐ Full Time Student ☐ Part Time Student ☐	ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED POLICY OR GROUP 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 SEX MM DD YY M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐	c. INSURANCE NAME OR PROGRAM NAME
d. INSURANCE NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ **If yes,** return to and complete item 9 a-d.
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of the government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		For Vytra Use Only
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) or PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB $ CHARGES YES ☐ NO ☐
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ . _____ 3. _____ . _____ 2. _____ . _____ 4. _____ . _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24.

A DATES OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K Reserved For Local Use
1.												
2.												
3.												
4.												
5.												
6.												

25. FEDERAL TAX ID NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES ☐ NO ☐	28. TOTAL CHARGES $	29. AMOUNT PAID $	30. BALANCE DUE $
☐ ☐					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NO.
SIGNED DATE		PIN # GRP#

PLEASE PRINT OR TYPE

PATIENT AND INSURED (EMPLOYEE) INSTRUCTIONS

1a. INSURED'S I.D. NUMBER
Enter the insured's identification number, including a prefix or suffix, exactly as it appears on the insured's identification card.

2. PATIENT'S NAME
Enter the last name, first name and middle initial of the patient. If the patient is the insured, spell the name exactly as it appears on his or her identification card.

3. PATIENT'S BIRTHDATE, SEX
Enter the month, day and year of the patient's birth. Place an "X" in the box which indicates the patient's sex.

4. INSURED'S NAME
Enter the last name, first name and middle initial of the insured. Spell the insured's name exactly as it appears on his or her identification card.

5. PATIENT'S ADDRESS, TELEPHONE NUMBER
Enter the patient's home or mailing address. This should include an apartment number, rural route, street number, street, post office box number, city, state and zip code. Enter the telephone number including area code.

6. PATIENT'S RELATIONSHIP TO THE INSURED
Place an "X" in the box which indicates the patient's relationship to the insured.

7. INSURED'S ADDRESS, TELEPHONE NUMBER
Enter the insured's home or mailing address. This should include an apartment number, rural route, street number, street, post office box number, city, state and zip code. Enter the telephone number including area code.

8. PATIENT'S STATUS
Place an "X" in the box which indicates the patient's status.

9. OTHER INSURED'S NAME, POLICY, EMPLOYER, PLAN
Enter other insured party's name (last, first, M.I.); (a) other insured party's insurance policy or group number; (b) other insured party's date of birth and sex ; (c) other insured party's employer or school name. The employer is an institution, organization or individual providing the principal source of medical coverage or financial support. Enter the name the other insured's school if the other insured party is a full-time student; (d) other insured party's plan or program name.

10. PATIENT'S CONDITION RELATED TO:
Place an "X" in the appropriate box, if the medical condition being treated is related to one of the listed situations.

11. INSURED'S POLICY, EMPLOYER, PLAN
Enter insured's insurance policy group number; (a) insured date of birth and sex ; (b) insured's employer or school name. The employer is an institution, organization or individual providing the principal source of medical coverage or financial support. Enter the name the insured's school if the insured party is a full-time student; (c) insured's plan or program name; (d) enter other insurance health benefit plan if any.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
The patient is to sign the claim form, authorizing the release of information, as provided below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my dependents for purposes of review, investigation or evaluation of this claim.

I also authorize Vytra Health Plans, or its agents, to disclose to a hospital or health care service plan, self insurer or an insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of this claim or term of coverage of my insurance policy, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon the claimant, his heirs, executors or administration."

INSTRUCTIONS: Attach original bills to this completed form and mail to Vytra Health Plans.

PHYSICIAN OR SUPPLIER INSTRUCTIONS *(Refer to billing instruction guide)*

Complete the physician or supplier section of the claim form and mail to:

Vytra Health Plans
PO Box 9091
Melville, NY 11747-9091