SWSCHP

PO BOX 5035, WHITE PLAINS, NEW YORK 10602-5035

Customer Service: 1-888-P-SWSCHP or 1-888-779-7247

ACTIVE & RETIREE <65 OUT-OF-NETWORK CLAIM FORM

For use ONLY when your provider is out of network and will not otherwise submit your claim.

FOR OFFICE USE ONLY: SWSACT

INSTRUCTIONS

To avoid processing delays, please fully complete all sections of this form and include a fully itemized bill.
If you have other coverage which is primary to SWSCHP, please include the primary carrier explanation of benefit statement.

PART A: MEMBER INFORMATION - COMPLETE THIS PART FOR ALL CLAIMS

1. MEMBER IDENTIFICATION NO.:

2. FULL NAME OF MEMBER (FIRST,MIDDLE,LAST):

3. DATE OF BIRTH:

4. GENDER: Δ MALE Δ FEMALE

PART B: PATIENT INFORMATION - COMPLETE THIS PART FOR ALL CLAIMS

5. PATIENT IDENTIFICATION NO.:

6. PATIENT NAME:

7. PATIENT DATE OF BIRTH:

8. PATIENT RELATIONSHIP TO MEMBER: Δ SELF Δ WIFE Δ HUSBAND Δ DOMESTIC PARTNER Δ CHILD

9. HOME PHONE (Include area code):

10. ADDRESS (NO & STREET):

11. APT. #:

12. CITY:

13. STATE:

14. ZIP CODE:

15. IS CLAIM DUE TO AN ACCIDENT? Δ YES Δ NO

16. IS CLAIM DUE TO AN EMPLOYMENT INJURY? Δ YES Δ NO

IF YES , TO 15 OR 16 DESCRIBE HOW/WHERE/WHEN ACCIDENT OCCURRED:

17. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE PROGRAM? Δ YES Δ NO

IF YES, PROVIDE THE NAME, ADDRESS, POLICY NUMBER AND EFFECTIVE DATE:

CHECK HERE IF THIS IS A NEW ADDRESS: Δ

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: **DATE:**

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.
SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE: **DATE:**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN OR PROVIDER OF SERVICES: I hereby authorize PAYMENT to the physician or provider of service.
SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE: **DATE:**

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