



## AUTHORIZATION

**Certification and Release of Information:** I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. This claim will be returned if this claim form is not signed.

**Applicants applying for accident and health insurance in New York:** Any person who knowingly and 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 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.

X \_\_\_\_\_  
Signature of Insured Member Date

## INSTRUCTIONS FOR THE USE OF THIS FORM

Dear SUNY Member:

This form was developed for you to notify HTH Worldwide of any covered health services for which we have not already been billed directly and to provide us with additional information that may be needed in order to process your claim. If a hospital, physician, ambulance company or other provider send their bill directly to you, HTH Worldwide has no way of knowing about your claim until the bill is received at HTH Worldwide.

Please read the following instructions about how to report health care services. We are happy to serve you.

### THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THE SERVICE TYPES LISTED BELOW

#### REGISTERED AND LICENSED VOCATIONAL NURSING SERVICES

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

#### PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT

- Doctor's orders or prescriptions
- Purchase price

#### OUTPATIENT PRESCRIPTION DRUGS

- Duplicate pharmacy generated receipt (not register tape)
- Must include prescribing doctor's name, name of medication, date filled and amount charged, Rx number; date filled; form, strength & quantity dispensed

#### AMBULANCE

- Pick-up and delivery points
- Number of miles

#### ANESTHESIA

- Start Time
- End Time
- Surgical procedure
- Surgeon Name and address

#### PHYSICAL THERAPY

- Medical Records
- Prescription from referring physician indicating the number of visits prescribed

### BILLS MUST BE ITEMIZED

Canceled check, cash register receipts and non-itemized "balance due" statements cannot be processed. If the bill is from a Hospital, Form UB-92 should be submitted. If being billed from a doctor a HCFA-1500 is preferable. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Provider taxpayer I. D. number
- Name of patient
- Date(s) of service
- Amount charged for each service
- Total Charge
- Diagnosis Code or reason for treatment
- Procedure Code(s) description of services performed

**HTH Worldwide**

PO Box 30259

Tampa, FL 33630

Telephone: 1.888.350.2002 Fax: 1.888.250.4121

Physicians/Providers:

For electronic filing Payor ID: 60054

**Reminder: This form is only to be used if treatment that was received in the United States.**