State University of New York Medical Reimbursement Form – Claims incurred inside the United States

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

PLEASE TYPE OR PRINT • USE A SEPARATE FORM FOR EACH PATIENT

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>PRIMARY POLICY HOLDER INFORMATION (on ID Card)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME Last</td>
<td>Cert#:</td>
</tr>
<tr>
<td>First</td>
<td>Group &amp; Name:</td>
</tr>
<tr>
<td>Middle</td>
<td>College/University Name:</td>
</tr>
<tr>
<td>BIRTH DATE</td>
<td>Last</td>
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<tr>
<td>SEX M F</td>
<td>First</td>
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<tr>
<td>RELATION TO SUBSCRIBER</td>
<td>Middle</td>
</tr>
<tr>
<td>YES NO</td>
<td>NAME Last</td>
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<tr>
<td>DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE?</td>
<td>First</td>
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<tr>
<td>YES NO</td>
<td>Middle</td>
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<tr>
<td>NAME OF OTHER HEALTH INSURANCE COMPANY</td>
<td>HOME PHONE NO.</td>
</tr>
<tr>
<td>CITY</td>
<td>ZIP CODE</td>
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<tr>
<td>STATE</td>
<td>COLLEGE ID NUMBER</td>
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**INJURY QUESTIONNAIRE**

If the condition related to this referral is a result of an accident/injury, please complete the following section.

Date of accident or beginning of condition:

Describe exactly how the accident took place:

Please indicate if the injury was related to any of the following:

- [ ] School related Injury
- [ ] Sports related injury
- [ ] Work related accident or illness
- [ ] Automobile/Motorcycle accident
  - [ ] intercollegiate sport
  - [ ] intramural sport

If the condition is a work related accident or a auto/motorcycle accident, please provide the following information:

Name of Employer: ____________________________ (For work related accident)

Name of Insurance Carrier: ___________________ (For auto/motorcycle accident)

Policy #: ____________________________

Address: ____________________________

Phone Number: ____________________________

Contact: ____________________________

**MEDICAL INFORMATION**

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

<table>
<thead>
<tr>
<th>Date of Service (Mo/Day/Yr)</th>
<th>Provider of Service (Name of Doctor, Lab, Ambulance Company, etc.)</th>
<th>Service Rendered (Office Visit, X-ray, Prescription, etc.)</th>
<th>Illness or Diagnosis</th>
<th>Total (Please Indicate Currency)</th>
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**GRAND TOTAL**

SUNY Claim Form 0610
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

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.