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.

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 Δ NON-BINARY**

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** **9. HOME PHONE (Include area code):**

Δ DOMESTIC PARTNER Δ CHILD

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.