SUBMIT CLAIMS TO: SIEBA, Ltd.
GROUP
111 Grant Ave, Ste 202
PO Box 5000
Endicott, NY 13761-5000

FOR VERIFICATION OR INFORMATION CALL:
(607) 786-3003
(800) 252-4624

HEALTH BENEFITS CLAIM FORM

PATIENT AND INSURED INFORMATION

1. PARTICIPANT'S SOCIAL SECURITY NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY — SEX M ☐ F ☐

4. PARTICIPANT'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. PARTICIPANT'S ADDRESS (No., Street)

CITY — STATE

ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY — SEX M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) ___

c. OTHER ACCIDENT? ☐ YES ☐ NO

If auto or other accident, please attach specific details and any necessary documentation.

11. PARTICIPANT'S GROUP NUMBER

a. PARTICIPANT'S DATE OF BIRTH MM | DD | YY — SEX M ☐ F ☐

b. PLAN SPONSOR

c. PLAN NAME

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.

SIGNED ______________________ DATE

13. PARTICIPANT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below, if assignment of benefits is allowed by my benefit plan.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM | DD | YY 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
FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place	Type	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS CODE	$ CHARGES	DAYS OR EPSDT	Family	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY	of	of								
1															
2															
3															
4															
5															
6															

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under personal direction.)

SIGNED

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 & PHONE #

PIN# — GRP #

PLEASE PRINT OR TYPE