HIP

SUBMISSION REQUIREMENTS FOR

HIP

THROUGH
FIRST NATIONAL ADMINISTRATORS
(2-50)

- ✓ Employer membership application completely filled out. Please make sure to fill out the options sheet and 3 page check list.
- ✓ Employee enrollment form completely filled out, including DOB and signature at bottom
- ✓ Waiver forms for those not enrolling only for groups with less than 25 employees
- ✓ Copy of Quote
- ✓ Itemized prior carrier list bill
- ✓ Total monthly premium made payable to "HIP of New York"
- ✓ Underwriting Checklist
- ✓ Proof of FT student status

Participation Requirements
0% - waivers are required for those not enrolling with groups less than 25 employees

Tax Documents - *subject to change according to HIP underwriters*

- Existing Group – Most recent NYS-45
- New Group – Business Cert or Incorporation Paperwork along with SS4, W4's and a letter from the CPA.
- Partnership – K1's for each partner and 1120S form

Effective Dates – 1st of the month

FNA is not responsible for changes made by the carrier. All subject to carrier approval.
Revised 2/24/09

2003 Jericho Turnpike, New Hyde Park NY 11040-4371 u (516)-352-7000 u Fax (516) 352-3135

SECTION VIII – NEW BUSINESS CHECKLISTS

HIP's Underwriting Guidelines Checklist for Small and Large Business

❑ The account indicated below qualifies for small business rates and benefits because the group's membership includes TWO (2) TO FIFTY (50) eligible employees.

❑ For large business 50 plus eligible employees.

Group Name _____

Completed by: Broker Signature _____ Date _____

CONTRIBUTION: Will group contribute toward the cost of coverage? ❑ Yes ❑ No
If "YES", will the group contribute the cost of:

❑ Employee Only Percentage _____ ❑ Dollar Amount _____
❑ Family _____

ELIGIBLE MEMBERS: (Check ALL boxes that apply to this group)

❑ Owners of the group/corporate officers/partners.
❑ Members of the Board of Directors.
❑ Employees on the group's payroll whose regular work schedule is at least 20 hours per week (if more than 20 employees, include active employees over 65 and spouse over 65.)
❑ Commissioned employees (no 1099s) with a base salary and commission.
❑ Eligible dependents of the group employees.
❑ Retirees & their spouses if the employer pays part or all premium as a retirement benefit.
❑ Former employee/dependants (COBRA continuation of coverage).
❑ Eligible union members (members must be employed by the same employer).

WHO MUST BE EXCLUDED FROM THE GROUP: (Check ALL boxes that apply to this group).

❑ Part-time employees who work less than 20 hours a week.
❑ Seasonal employees whose employment is six months or less each year.
❑ Temporary employees (HIP does not cover temporary workers).
❑ Employees who do not "work or reside" in the HIP service area.
❑ Employees in the armed forces of any government other than for duty of 30 days or less.
❑ Union-affiliated employees.
❑ HIP does not cover babysitter or personal maids.

TYPES OF ORGANIZATIONS: (Check ONE box that applies to this group).

- ❑ Sole proprietorship.
- ❑ Business establishment.
- ❑ Partnership or corporation.
- ❑ Not-for-profit organization (employees must work a minimum of 20 hours).
- ❑ Government body (state, county or municipal).
- ❑ Union or Union Management Welfare Fund (members and/or employees of a union and their dependents).
- ❑ Association, Chamber of Commerce, Professional Society.
- ❑ OTHER (Describe):_____

DOCUMENTS THAT MUST BE SUBMITTED TO ENROLL:

- ❑ Completed Group Application.
- ❑ Employee(s) ENROLLMENT APPLICATION(S) with PRE-EXISTING CLAUSE: See "Election of Coverage and Authorization", paragraph 3. (Employer must sign bottom of form.)
- ❑ **Requested EFFECTIVE DATE MUST be the 1st or 15th of the month.**
- ❑ Waiver Forms (For Groups of 2-24 employees). (For employees with other coverage who are excluded or who refuse coverage.)
- ❑ Copy of the NYS-45. Must indicate NYS Tax ID.
- ❑ Business check for the first month's premium for both large & small businesses.

ADDITIONAL REQUIRED DOCUMENTS:

- ❑ For any employee NOT listed on the NYS-45, submit a copy of the payroll check showing the company's name along with the employee name, SS# and a W-4.
- ❑ College/university STUDENT VERIFICATION of active full time status (minimum of 12 credits).
- ❑ Owners/Partners of the business NOT reflected on the NYS-45, submit a copy of any other official document substantiating the name of the owners/partners and the company's name.
- ❑ NEW BUSINESS: Submit an accountant's letter indicating the date the business started and the number of eligible employees, along with a business certificate.
- ❑ MEMBERS OF THE BOARD OF DIRECTORS, submit a copy of the annual report indicating the names of the directors.
- ❑ COBRA Continuees:
  - ❑ Copy of the company's last NYS-45 which includes the former employee.
  - ❑ Copy of the individual's COBRA election form. In the absence of the election form, a letter from the former employee/dependant resulting continuation of coverage and the date of the qualifying event may be submitted.

SMALL GROUP ONLY PRE-EXISTING CONDITIONS INFORMATION

- ❑ For new business: Copy of the premium billing statement (or statements if more than one insurance carrier provided coverage) from 12 months preceding the effective date of HIP coverage. For any employee NOT listed on that bill, a "Certificate of Credible Coverage" must be submitted verifying their previous health insurance.

FOR SECURITY REASONS, PLEASE MAKE ALL CHECKS PAYABLE TO:
HIP HEALTH PLAN OF NEW YORK (NOT HIP)

MARKETING REP'S NAME_____
Please Print

BROKER'S NAME_____
Please Print

PLEASE RETURN A COMPLETED COPY OF THIS FORM PLUS ALL OTHER REQUIRED DOCUMENTS AS INDICATED ABOVE TO:_____

Important Deadlines:
Any groups received from the **1st** through the **15th** of the current month can be processed with an effective date of either the **1st** or **15th** of the current month.

All groups received on the **16th** through the end of the current month can be processed ONLY for the effective date of the **1st** of the following month.

Other dates will ONLY be considered if HIP is taking over coverage from another POS plan.

THE GROUP AGREES TO DO THE FOLLOWING:

- Make payroll deductions, if employee contributions are required, and remit to HIP Health Plan of New York the premiums payable in accordance with the terms of the Contract. Failure to pay on time could result in the termination of the group's coverage.
- Promptly notify HIP Health Plan of New York of the termination or addition of any Member(s) covered or to be covered by HIP.
- Promptly provide HIP Health Plan of New York with any information necessary to properly administer the coverage.
- Ensure compliance with TEFRA/DEFRA/COBRA/OBRA and any other legislation pertaining to group's coverage.

IT IS UNDERSTOOD THAT:

- If an acceptable employee enrollment form is received prior to the eligibility date coverage will begin on the date of eligibility.
- If an acceptable employee enrollment form is received subsequent to the eligibility date, coverage will begin on the date of receipt.
- All group applications are subject to approval by HIP Health Plan of New York.

I, the undersigned, understand and agree that this application is for health insurance coverage offered by HIP Health Plan of New York, and will form a part of any Contract issued in reliance upon it. Acceptance of the group for coverage and the final rates are based upon the above information and the census of the actual enrollees. Any material misrepresentation within this group application or the group's census, whether intentional or unintentional, will permit HIP Health Plan of New York to terminate this coverage subject to the terms of the Contract. I understand and agree that it is my responsibility to offer coverage to all eligible employees and their dependents; and I will provide to HIP Health Plan of New York an enrollment form or a waiver of coverage form (applicable to groups with 2-50 eligible employees) signed by each eligible employee within thirty (30) days of his/her eligibility date.

I also understand that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. I am submitting a one (1) month premium deposit to be held without obligation until this application is approved. This premium deposit will be applied to the applicable premium billing/payment frequency I selected under this Contract. HIP Health Plan will refund the premium deposit submitted with this application if coverage does not become effective.

Subject to applicable State and Federal laws pertaining to preexisting conditions and creditable coverage, benefits for preexisting conditions may not be payable for up to twelve months from the effective date of this Contract.

All statements in this application for coverage under a Contract from HIP Health Plan of New York shall be deemed representations and not warranties, and no such statements shall be used to deny a claim under the Contract, unless the statements are made in the application or in addenda attached to the Contract.

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 material fact associated with such application commits a fraudulent insurance act. Such act is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at:_____ On the _____Day of, _____ ,20_____

By:_____ Title:_____

(Printed name of authorized officer)

By:_____

(Signature of authorized officer)

Please return this completed application and the following items:

- "Employer's Quarterly Report of Wages Paid to Each Employee (NYS — 45)"
- Copy of a 12 month old (or more recent, if necessary) billing statement
- First month's premium

To: **HIP Health Plan of New York**
New Business/Sales
Attn: Broker Administrative Rep.
55 Water Street
New York, NY 10041

COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING

HIP **HEALTH INSURANCE PLAN OF GREATER NEW YORK**
and HIP INSURANCE COMPANY OF NEW YORK 55 Water Street New York, NY 10041

GROUP APPLICATION

Section 1 – APPLICANT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Requested Effective Date:							
Company's Legal Name:						SIC Code:	
Company DBA, if applicable:							
Company's Address (No. and Street):				Billing Address, if different:			
City	State	Zip	County	City	State	Zip	County
Company Officer:				Title:		Telephone:	
Company Contact Person:				Title:		Telephone:	
E-mail Address:				Fax Number:			
How long has your company been at the current address?				Indicate your Company's State Employer Identification Number:			
What is the nature of the Business or Organization?							

Which of the following describes your Company or Organization?

☐ Employer/Employee Group ☐ Business Association ☐ Fraternal/ Religious Organization
☐ Sole Proprietor ☐ Partnership ☐ Non-Profit Organization
☐ Other Group, please describe _____

Which of the following describes your type of Association?

☐ Trade Association ☐ Labor Union and Employer Trust ☐ Professional Association
☐ Chamber of Commerce ☐ Credit or Bank Association
☐ Special Association (Approved by Department of Insurance)

Is your Company or Organization a Subsidiary, Division or an Affiliate of another Company?

☐ Yes ☐ No If Yes, please complete the following:

Company Name	Address	Number of Total Employees

Select Product Coverage:

☐ PRIME HMO ☐ *access* I ☐ HIP PRIME Dental PPO ☐ PRIME EPO ☐ SMART START EPO

☐ PRIME POS ☐ *access* II ☐ HIP VIP Medicare ☐ PRIME PPO

☐ SELECT EPO ☐ SELECT PPO ☐ HIP CLASSIC ☐ Other: _____

HIP GROUP APPLICATION

Section 2a – EMPLOYEE INFORMATION

(For Small Groups 2-50 employees and Large Groups 51+ employees)

PLEASE TYPE OR PRINT LEGIBLY

Eligible Employees: Employees on your payroll whose regular work schedule is at least [20.0] hours per week.

A - Total Number of Employees_____ C - Number of Employees Enrolling for Coverage _____

B* - Number of Employees Eligible for Coverage _____ D - Number of Employees Waiving Coverage (B-C) _____

Reasons for Waiver(s):

WAITING PERIOD:

PRESENT EMPLOYEES' ELIGIBILITY — Will all current employees be covered as of the effective date of coverage?

☐ Yes ☐ No If no, explain: _____

FUTURE EMPLOYEES' ELIGIBILITY — New employees will be eligible for coverage:

☐ Date of Hire ☐ First day of the month following date of hire

☐ ____ Month(s) following the date of hire ☐ Other_____

CONTRIBUTIONS: Will the Group contribute 100% of the cost of the coverage? ☐ Yes ☐ No If no, complete below:

	Group Contribution Dollar Amount	or	Percentage
☐ Employee only coverage	$ _____		_____%
☐ Employee and Spouse	$ _____		_____%
☐ Employee and Child(ren)	$ _____		_____%
☐ Family	$ _____		_____%

If group contributes 100% of the cost of coverage, all eligible employees must participate.

PREMIUM BILLING/PAYMENT FREQUENCY: ☐ Monthly ☐ Quarterly ☐ Semi- Annually ☐ Annually

Section 2b – SOLE PROPRIETOR INFORMATION

A Sole Proprietor purchasing coverage through an association must be a member of the association for at least 60 days prior to the effective date of the insurance coverage.

To be eligible to purchase Sole Proprietor health insurance, please provide the following with the application and on an annual basis:

1. A copy of the New York tax form NYS-45ATT-MN, or other comparable documentation of active employees status such as a copy of a pay stub or estimated tax form;
2. For a business in operation for more than 1 year, the prior year's federal income tax Schedule C for an incorporated business subject to Subscriber S with a Sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or
3. For a business in operation for less than one year, a cancelled business check, a copy of a business bank statement, a certificate of doing business, or appropriate tax documentation; and
4. Such other documentation as may be reasonably required by the insurer and as approved by the Superintendent to verify eligibility of an individual to purchase health insurance pursuant to Chapter 557.

PAYMENT FREQUENCY: ☐ Monthly ☐ Quarterly ☐ Semi- Annually ☐ Annually

HIP GROUP APPLICATION

Section 3 – REPLACEMENT INFORMATION

PLEASE TYPE OR PRINT LEGIBLY

Does this Group Contract replace other coverage? ☐ Yes ☐ No

If "Yes", please attach a copy of a billing statement from 12 months ago* (or more recent, if necessary) and complete the following:

	Effective Date	Termination Date	Prior Carrier
HMO	_____	_____	_____
POS	_____	_____	_____
Indemnity	_____	_____	_____
PPO/EPO	_____	_____	_____
Dental	_____	_____	_____
Other	_____	_____	_____

** Note: A billing statement from 12 months ago will reduce the probability that employees will need to provide evidence of prior coverage. Eligible employees with less than 12 months of continuous coverage may be required to submit a 'Certificate of Creditable Coverage" with their enrollment form.*

Section 4 –- GENERAL AGENT/BROKER INFORMATION

General Agent Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

Broker Name: _____

Address: _____

Telephone: _____ Fax _____

Number: _____

E-mail Address: _____

For Office Use Only

HIP Marketing Representative and Code:

Broker/Agent:

Group Number (To Be Completed by Underwriting):

HIP Health Plan of NY

Late Paperwork Form

Agents/Brokers/Administrators: If you are submitting group enrollment paperwork 10 calendar days (or less) prior to the group's requested effective date, this form must be filled out by the group administrator, signed and submitted with their complete paperwork.

Group Name: _____

Address: _____

We the undersigned, understand that we are requesting a coverage date that will put our enrollment paperwork in the HIP's home office(s) 10 days (or less) prior to our effective date, that it will take approximately 10 business days to completely process all paperwork and that delivery of our ID cards will occur after this process is complete which is after our effective date.

Upon approval of our request for insurance, we acknowledge that the delivery of our group's ID cards and system activation may occur after our effective date.

Name (Please Print): _____

Signature: _____

Date: _____

HIP®

HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP PRIME for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $5	☐ $10	☐ $15	☐ $20	
Specialist Office Visit	☐ $5	☐ $10	☐ $15	☐ $20	
Inpatient Hospital	☐ $0	☐ $250	☐ $500		
	or				
	☐ $0	☐ $50	☐ $100	☐ $250	each day for the first ☐ three; ☐ five days of copayment per continuous confinement
Ambulatory Surgery	☐ $0	☐ $50	☐ $75		
Emergency Room	☐ $35	☐ $50			

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COINSURANCE

☐ $1 ☐ $2.50 ☐ $5 ☐ $7 ☐ $10 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $50

DEDUCTIBLE

☐ $0 ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300
☐ $400 ☐ $500

ANNUAL MAXIMUM

☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

☐ 0 Visits	☐ $5 Copay	☐ $30 Copay
☐ 20 Visits	☐ $10 Copay	☐ $35 Copay
☐ 30 Visits	☐ $15 Copay	☐ $40 Copay
☐ 40 Visits	☐ $20 Copay	☐ No Copay
☐ 60 Visits	☐ $25 Copay	

OR

Visits 1-3		**Visits 4-20**
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits ☐ 120 Visits ☐ $0 Copay
☐ $2 Copay ☐ $5 Copay
☐ $10 Copay ☐ $15 Copay
☐ $20 Copay ☐ $25 Copay

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits
☐ 100 Visits

REFRACTIVE EYE EXAM

☐ $0 Copay ☐ $15 Copay
☐ $2 Copay ☐ $20 Copay
☐ $5 Copay ☐ $25 Copay
☐ $10 Copay

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

OPTICAL (Select One)

☐ One pair eyeglasses every 12 months;
$25 contact lens copayment

☐ One pair eyeglasses every 24 months;
$25 contact lens copayment

☐ One pair eyeglasses and contact lenses,
covered up to a maximum of $75 every 12 months

☐ No Rider

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP

HIP INSURANCE COMPANY OF NEW YORK

HIP PRIME EPO for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
Specialist Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
	☐ $30	☐ $35	☐ $40					
Inpatient Facility	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500		
	-Or-							
	☐ $0	☐ $50	☐ $100	☐ $250	each day of the first three ☐ five ☐ days of copayment per continuous confinement			
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100				
Emergency Room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COST SHARING

☐ $1	☐ $2.50	☐ $5	☐ $7	☐ $10	☐ $25	☐ $30
☐ $35	☐ $40	☐ $50	☐ 50%			

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

☐ Covered In Full

☐ Excluded

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits
☐ 120 Visits
☐ $0 Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits
☐ 100 Visits
☐ 120 Visits

REFRACTIVE EYE EXAM

☐ $0 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

OPTICAL

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copayment

☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months

☐ No Rider

OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3		Visits 4-20
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP

HIP INSURANCE COMPANY OF NEW YORK

HIP PRIME PPO for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
Specialist Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
	☐ $30	☐ $35	☐ $40					
Inpatient Facility	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500		
	-Or-							
	☐ $0	☐ $50	☐ $100	☐ $250	each day for the first three ☐ five ☐ days of copayment per continuous confinement			
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100				
Emergency Room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ **100%** ☐ **80%** ☐ **75%** ☐ **70%** ☐ **50%**

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual Family	☐ **$200 $400**	☐ **$250 $500**	☐ **$300 $600**	☐ **$350 $700**	☐ **$400 $800**
	☐ **$500 $1,000**	☐ **$750 $1,500**	☐ **$1,000 $2,000**	☐ **$1,500 $3,000**	☐ **$2,000 $4,000**
	☐ **$2,500 $5,000**	☐ **$5,000 $10,000**	☐ **$10,000 $20,000**	☐ **No Deductible**	☐ **Other $** _____ **$** _____
	☐ **$300 $750**	☐ **$500 $1,250**	☐ **$1,500 $3,750**		

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual Family	☐ **$1,000 $2,000**	☐ **$1,500 $3,000**	☐ **$2,000 $4,000**	☐ **$3,000 $6,000**	☐ **$4,000 $8,000**
	☐ **$5,000 $10,000**	☐ **$7,000 $14,000**	☐ **$7,500 $15,000**	☐ **$10,000 $20,000**	☐ **$20,000 $40,000**

☐ **Other $** _____
$ _____

HIAA REIMBURSEMENT (Select One)

☐ **70th Percentile** ☐ **80th Percentile** ☐ **90th Percentile**

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COST SHARING

☐ $1 ☐ $2.50 ☐ $5 ☐ $7 ☐ $10 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $50 ☐ 50%

DEDUCTIBLE

☐ $0 ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300
☐ $400 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000

ANNUAL MAXIMUM

☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____
☐ 20% Coinsurance
☐ 25% Coinsurance
☐ 30% Coinsurance

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

REFRACTIVE EYE EXAM

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3

☐ No Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $30 Copay
☐ $35 Copay
☐ $40 Copay

Visits 4-20

☐ $25 Copay

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits
☐ 120 Visits
☐ 50% Coinsurance (out-of-network)

HOME HEALTH CARE

☐ 40 visits (standard)
☐ 60 visits
☐ 100 visits
☐ 200 visits
☐ $1 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ No Copay

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits (standard)
☐ $2 Copay
☐ $15 Copay
☐ 120 Visits
☐ $5 Copay
☐ $20 Copay
☐ $0 Copay
☐ $10 Copay
☐ $25 Copay

OPTICAL (Select One)

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copayment

☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months

☐ No Rider

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

MONTHLY RATES (to be completed by your broker or HIP)

4 TIER	Individual	$_____
	Employee & Child(ren)	$_____
	Employee & Spouse	$_____
	Family	$_____

HIP®

HEALTH INSURANCE PLAN of GREATER NEW YORK & HIP INSURANCE COMPANY OF NEW YORK

HIP PRIME POS for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25
Specialist Office Visit	☐ $0 ☐ $30	☐ $2 ☐ $35	☐ $5 ☐ $40	☐ $10	☐ $15	☐ $20	☐ $25
Hospital Admission Copayment	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500	
	or						
	☐ $0	☐ $50	☐ $100	☐ $250	each day for the first ☐ three; ☐ five days of copayment per continuous confinement		
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100			
Emergency Room	☐ $0 ☐ $100	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ **80%** ☐ **75%** ☐ **70%** ☐ **50%**

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual Family	☐ **$200** **$400**	☐ **$250** **$500**	☐ **$300** **$600**	☐ **$400** **$800**	☐ **$1,000** **$2,000**
	☐ **$2,000** **$4,000**	☐ **$5,000** **$10,000**	☐ **$10,000** **$20,000**	☐ Other	$_____ $_____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual Family	☐ **$1,000** **$2,000**	☐ **$1,500** **$3,000**	☐ **$2,000** **$4,000**	☐ **$3,000** **$6,000**	☐ **$4,000** **$8,000**
	☐ **$5,000** **$10,000**	☐ **$7,000** **$14,000**	☐ **$7,500** **$15,000**	☐ **$10,000** **$20,000**	☐ **$20,000** **$40,000**

☐ Other $_____
$_____

HIAA REIMBURSEMENT (Select One)

☐ **70th Percentile** ☐ **80th Percentile** ☐ **90th Percentile**

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay

☐ $0
☐ $1
☐ $2
☐ $2.50
☐ $5
☐ $7
☐ $10
☐ $15
☐ $20
☐ $25

Brand Name Copay

☐ $0
☐ $1
☐ $2
☐ $2.50
☐ $5
☐ $7
☐ $10
☐ $12
☐ $15
☐ $20
☐ $25
☐ $30
☐ $35
☐ No Brand

NON-FORMULARY DRUG COINSURANCE

☐ $1
☐ $2.50
☐ $5
☐ $7
☐ $10
☐ $25
☐ $30
☐ $35
☐ $40
☐ $50
☐ 50%

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

☐ Covered In Full
☐ $100 Deductible, then Covered in Full
☐ Not Covered
☐ Other: _____

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits

☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3		Visits 4-20
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

OUTPATIENT THERAPIES

☐ 30 Visits (standard) 50% coinsurance (Out-of-Network)
☐ 60 Visits
☐ 90 Visits
☐ 100 Visits
☐ 120 Visits

REFRACTIVE EYE EXAM

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits
☐ $2 Copay
☐ $10 Copay
☐ $20 Copay

☐ 120 Visits
☐ $5 Copay
☐ $15 Copay
☐ $25 Copay

☐ $0 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

OPTICAL (Select One)

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copayment

☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months

☐ No Rider

MONTHLY RATES (to be completed by your broker or HIP)

4 TIER	Individual	$_____
	Employee & Child(ren)	$_____
	Employee & Spouse	$_____
	Family	$_____

HIP®

HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP*access* I for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25
Specialist Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25
	☐ $30	☐ $35	☐ $40				
Inpatient Hospital	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500	
	or						
	☐ $0	☐ $50	☐ $100	☐ $250	each day for the first ☐ three; ☐ five days of copayment per continuous confinement		
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100			
Emergency Room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75
	☐ $100						

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COST SHARING

☐ $1 ☐ $2.50 ☐ $5 ☐ $7 ☐ $10 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $50 ☐ 50%

DEDUCTIBLE

☐ $0 ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300
☐ $400 ☐ $500

ANNUAL MAXIMUM

☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $4,000 ☐ $5,000

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

OUTPATIENT MENTAL HEALTH *(must choose a visit & copay)*

☐ 0 Visits	☐ $5 Copay	☐ $30 Copay
☐ 20 Visits	☐ $10 Copay	☐ $35 Copay
☐ 30 Visits	☐ $15 Copay	☐ $40 Copay
☐ 40 Visits	☐ $20 Copay	☐ No Copay
☐ 60 Visits	☐ $25 Copay	

OR

Visits 1-3		**Visits 4-20**
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits ☐ 120 Visits ☐ $0 Copay
☐ $2 Copay ☐ $5 Copay ☐ $10 Copay
☐ $15 Copay ☐ $20 Copay
☐ $25 Copay

REFRACTIVE EYE EXAM

☐ $0 Copay ☐ $15 Copay
☐ $2 Copay ☐ $20 Copay
☐ $5 Copay ☐ $25 Copay
☐ $10 Copay

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

OPTICAL (Select One)

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copayment

☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months

☐ No Rider

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits
☐ 120 Visits

DURABLE MEDICAL EQUIPMENT

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP®

HEALTH INSURANCE PLAN of GREATER NEW YORK & HIP INSURANCE COMPANY OF NEW YORK

HIP*access* II for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
Specialist Office Visit	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	
	☐ $30	☐ $35	☐ $40					
Inpatient Facility	☐ $0	☐ $100	☐ $150	☐ $200	☐ $250	☐ $500		
	-Or-							
	☐ $0	☐ $50	☐ $100	☐ $250	each day for the first three ( ) five ( ) days of copayment per continuous confinement			
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100				
Emergency Room	☐ $0	☐ $15	☐ $25	☐ $35	☐ $50	☐ $60	☐ $75	☐ $100

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ **100%** ☐ **80%** ☐ **75%** ☐ **70%** ☐ **50%**

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual Family	☐ **$200 $400**	☐ **$250 $500**	☐ **$300 $600**	☐ **$350 $700**	☐ **$400 $800**
	☐ **$500 $1,000**	☐ **$750 $1,500**	☐ **$1,000 $2,000**	☐ **$1,500 $3,000**	☐ **$2,000 $4,000**
	☐ **$2,500 $5,000**	☐ **$5,000 $10,000**	☐ **$10,000 $20,000**	☐ **No Deductible**	☐ **Other $ _____ $ _____**
	☐ **$300 $750**	☐ **$500 $1,250**	☐ **$1,500 $3,750**		

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual Family	☐ **$1,000 $2,000**	☐ **$1,500 $3,000**	☐ **$2,000 $4,000**	☐ **$3,000 $6,000**	☐ **$4,000 $8,000**
	☐ **$5,000 $10,000**	☐ **$7,000 $14,000**	☐ **$7,500 $15,000**	☐ **$10,000 $20,000**	☐ **$20,000 $40,000**

☐ **Other $ _____**
$ _____

HIAA REIMBURSEMENT (Select One)

☐ **70th Percentile** ☐ **80th Percentile** ☐ **90th Percentile**

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COINSURANCE

☐ $1	☐ $2.50	☐ $5	☐ $7	☐ $10	☐ $25	☐ $30
☐ $35	☐ $40	☐ $50	☐ 50%			

DEDUCTIBLE

☐ $0	☐ $50	☐ $100	☐ $150	☐ $200	☐ $250	☐ $300
☐ $400	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000		

ANNUAL MAXIMUM

☐ $1,000	☐ $2,000	☐ $2,500	☐ $3,000	☐ $4,000	☐ $5,000

PRIVATE DUTY NURSING (Select One)

☐ Covered In Full

☐ Excluded

DIALYSIS TREATMENT

☐ $0 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Hospital Admission Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ Not Covered
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits
☐ 120 Visits
☐ 50% Coinsurance

HOME HEALTH CARE

☐ 40 visits (standard)
☐ 60 visits
☐ 100 visits
☐ 200 visits
☐ $1 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ No Copay

OPTICAL (Select One)

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copayment

☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months

☐ No Rider

DURABLE MEDICAL EQUIPMENT (Select One)

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____
☐ 20% Coinsurance
☐ 25% Coinsurance
☐ 30% Coinsurance

REFRACTIVE EYE EXAM

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

OUTPATIENT MENTAL HEALTH

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits
☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3		Visits 4-20
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits
☐ $2 Copay
☐ $10 Copay
☐ $20 Copay
☐ 120 Visits
☐ $5 Copay
☐ $15 Copay
☐ $25 Copay
☐ $0 Copay

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End of year	☐ 19 End of Month
☐ 25 End of year	☐ 23 End of year
	☐ 25 End of year

MONTHLY RATES (to be completed by your broker or HIP)

4 TIER	Individual	$_____
	Employee & Child(ren)	$_____
	Employee & Spouse	$_____
	Family	$_____

HIP INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY OF NEW YORK

HIPIC SELECT EPO for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

Office Visit PCP	☐ $0	☐ $2	☐ $5	☐ $10	☐ $15	☐ $20	☐ $25	☐ $30
Office Visit Specialist	☐ $0 ☐ $35	☐ $2 ☐ $40	☐ $5 ☐ $45	☐ $10 ☐ $50	☐ $15	☐ $20	☐ $25	☐ $30
Ambulatory Surgery	☐ $0	☐ $50	☐ $75	☐ $100	☐ **Subject to Deductible and Coinsurance**			
Hospital Admission Copayment	**Per Admission:**		☐ $0	☐ $100	☐ $200	☐ $250	☐ $500	
	or							
	☐ $0	☐ $50	☐ $100	each day for the first ☐ three; ☐ five days of copayment per continuous confinement				
	☐ **Subject to Deductible and Coinsurance**							
Emergency Room	☐ $ 0	☐ $25	☐ $35	☐ $50	☐ $75	☐ $100		
	☐ **Subject to Deductible and Coinsurance**							

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ **80%** ☐ **90%** ☐ **100%**

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual Family	☐ **$0** **$0**	☐ **$500** **$1,000**	☐ **$1,000** **$2,000**	☐ **$1,500** **$3,000**	☐ **Other**	**$** _____ **$** _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual Family	☐ **$0** **$0**	☐ **$2,000** **$4,000**	☐ **$2,500** **$5,000**	☐ **$3,000** **$6,000**	☐ **Other**	**$** _____ **$** _____

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COST SHARING

☐ $1	☐ $2.50	☐ $5	☐ $7	☐ $10	☐ $25	☐ $30
☐ $35	☐ $40	☐ $50	☐ 50%			

PRIVATE DUTY NURSING

☐ Covered In Full
☐ 80% for hours 73 - 504
☐ 100% for hours 73- 504
☐ Not Covered

DURABLE MEDICAL EQUIPMENT

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____

SKILLED NURSING FACILITY

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ 120 Days
☐ Unlimited Days

☐ $0 Copay
☐ Deductible, then Coinsurance

HOME HEALTH CARE

☐ 40 Visits (standard)
☐ 60 Visits
☐ 100 Visits
☐ 200 visits

☐ $0 Copay
☐ Deductible, then Coinsurance

INPATIENT THERAPIES

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ Not covered

☐ Deductible, then Coinsurance

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits

☐ Not covered

INPATIENT MENTAL HEALTH

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ Not covered

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT MENTAL HEALTH

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits

☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3		Visits 4-20
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

PRE-HOSPITAL EMERGENCY SERVICES

☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $35 Copay

☐ $50 Copay
☐ $75 Copay
☐ $100 Copay

☐ No Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered
☐ 30 Days
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits (standard)
☐ 120 Visits

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay

☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days
☐ Not covered

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)

☐ $25 Copay
☐ $20 Copay

REFRACTIVE EYE EXAM

☐ $0 Copayment (standard)
☐ $15 Copayment
☐ $20 Copayment
☐ $25 Copayment

FITNESS CENTER (Membership Reimbursement)

☐ $200

OPTICAL

☐ One pair eyeglasses every 12 months;
$25 contact lens copayment

☐ One pair eyeglasses every 24 months;
$25 contact lens copayment

☐ One pair eyeglasses every 12 months;
$70 contact lens copayment

☐ One pair eyeglasses every 24 months;
$70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copay;
No contact lens option

☐ No Rider

DEPENDENT COVERAGE

Full-Time Students	Dependent Children
☐ 23 End Of Month	☐ 19 End Of Month
☐ 23 End Of Year	☐ 19 End Of Year
☐ Other (enter below)	
Age: _____	_____
☐ End Of Year	☐ End Of Year
☐ End Of Month	☐ End Of Month

OTHER

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Two Persons	
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY OF NEW YORK

HIPIC SELECT PPO for SMALL GROUPS (2-50 Employees)

☐ **HIP PRIME NETWORK** ☐ **VYTRA PREMIUM NETWORK**

Group Name .....

IN-NETWORK BENEFITS

COPAYMENT OPTIONS (Select One from each category)

Office Visit PCP
☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30

Office Visit Specialist
☐ $0 ☐ $2 ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $45 ☐ $50

Ambulatory Surgery
☐ $0 ☐ $50 ☐ $75 ☐ $100 ☐ **Subject to Deductible and Coinsurance**

Hospital Admission Copayment
Per Admission: ☐ $0 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $500
or
☐ $0 ☐ $50 ☐ $100 ☐ $250 each day for the first ☐ three; ☐ five days of copayment per continuous confinement
☐ **Subject to Deductible and Coinsurance**

Emergency Room
☐ $ 0 ☐ $15 ☐ $25 ☐ $35 ☐ $50 ☐ $75 ☐ $100
☐ **Subject to Deductible and Coinsurance**

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 80% ☐ 90% ☐ 100%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	$0	$100	$200	$300	$500	$1,000	$1,500
Family	$0	$200	$400	$600	$1,000	$2,000	$3,000

☐ $2,000 / $4,000 ☐ OTHER $ _____
$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	$0	$500	$750	$1,000	$2,000	☐ OTHER $ _____
Family	$0	$1,000	$1,500	$2,000	$4,000	$ _____

OUT-OF-NETWORK BENEFITS

COINSURANCE PERCENTAGE (Select One)

Percentage of covered charges payable by HIP Insurance Company:

☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90%

DEDUCTIBLE OPTIONS (Select One)

Annual Deductible payable by member:

Individual	$250	$500	$750	$1,000	$3,000	☐ OTHER $ _____
Family	$500	$1,000	$1,500	$2,000	$6,000	$ _____

COINSURANCE MAXIMUM (Select One)

Maximum Coinsurance amount payable by member:

Individual	$1,000	$3,000	$7,000	$10,000	$20,000	☐ OTHER $ _____
Family	$2,000	$6,000	$14,000	$20,000	$40,000	$ _____

HIAA REIMBURSEMENT (Select One)

☐ **70th Percentile** ☐ **80th Percentile** ☐ **90th Percentile**

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

☐ **NO PRESCRIPTION DRUG COVERAGE**

FORMULARY DRUG COPAYMENTS

Generic Copay		**Brand Name Copay**	
☐ $0	☐ $15	☐ $0	☐ $12
☐ $1	☐ $20	☐ $1	☐ $15
☐ $2	☐ $25	☐ $2	☐ $20
☐ $2.50		☐ $2.50	☐ $25
☐ $5		☐ $5	☐ $30
☐ $7		☐ $7	☐ $35
☐ $10		☐ $10	☐ No Brand

NON-FORMULARY DRUG COST SHARING

☐ $1 ☐ $2.50 ☐ $5 ☐ $7 ☐ $10 ☐ $25 ☐ $30
☐ $35 ☐ $40 ☐ $50 ☐ 50%

PRIVATE DUTY NURSING

☐ Covered In Full
☐ 80% for hours 73 - 504
☐ 100% for hours 73- 504
☐ Not Covered

DURABLE MEDICAL EQUIPMENT

☐ Covered In Full
☐ $100 Deductible, then Covered In Full
☐ Not Covered
☐ Other: _____

☐ 20% Coinsurance
☐ 25% Coinsurance
☐ 30% Coinsurance

SKILLED NURSING FACILITY

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ 120 Days
☐ Unlimited Days

☐ $0 Copay
☐ Deductible, then Coinsurance

HOME HEALTH CARE

☐ 40 Visits (standard)
☐ 60 Visits
☐ 100 Visits
☐ 200 visits

☐ $0 Copay
☐ Deductible, then Coinsurance

INPATIENT THERAPIES

☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days
☐ Not covered

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT THERAPIES

☐ 30 Visits (standard)
☐ 60 Visits
☐ 90 Visits

☐ Not covered

INPATIENT MENTAL HEALTH

☐ 0 Days
☐ 30 Days (standard)
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT MENTAL HEALTH

☐ 0 Visits
☐ 20 Visits
☐ 30 Visits
☐ 40 Visits
☐ 60 Visits

☐ $5 Copay
☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

☐ $30 Copay
☐ $35 Copay
☐ $40 Copay
☐ No Copay

OR

Visits 1-3		Visits 4-20
☐ No Copay	☐ $20 Copay	☐ $25 Copay
☐ $2 Copay	☐ $25 Copay	
☐ $5 Copay	☐ $30 Copay	
☐ $10 Copay	☐ $35 Copay	
☐ $15 Copay	☐ $40 Copay	

PRE-HOSPITAL EMERGENCY SERVICES

☐ $15 Copay
☐ $20 Copay
☐ $25 Copay
☐ $35 Copay

☐ $50 Copay
☐ $75 Copay
☐ $100 Copay

☐ No Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ Not Covered
☐ 30 Days
☐ 60 Days
☐ 90 Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

OUTPATIENT ALCOHOL/SUBSTANCE ABUSE REHABILITATION

☐ 60 Visits (standard)
☐ 120 Visits

☐ $0 Copay
☐ $2 Copay
☐ $5 Copay

☐ $10 Copay
☐ $15 Copay
☐ $20 Copay
☐ $25 Copay

INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION

☐ 0 Days
☐ 7 Days
☐ 21 Days
☐ 30 Days
☐ Unlimited Days

☐ $ Hospital Admission Copay
☐ Deductible, then Coinsurance

ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)

☐ $25 Copay
☐ $20 Copay

REFRACTIVE EYE EXAM

☐ $0 Copayment (standard)
☐ $15 Copayment
☐ $20 Copayment
☐ $25 Copayment

FITNESS CENTER (Membership Reimbursement)

☐ $200

OPTICAL

☐ One pair eyeglasses every 12 months; $25 contact lens copayment

☐ One pair eyeglasses every 24 months; $25 contact lens copayment

☐ One pair eyeglasses every 12 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months; $70 contact lens copayment

☐ One pair eyeglasses every 24 months with $45 copay; No contact lens option

☐ No Rider

DEPENDENT COVERAGE

Full-Time Students	Dependent Children
☐ 23 End Of Month	☐ 19 End Of Month
☐ 23 End Of Year	☐ 19 End Of Year
☐ Other (enter below)	
Age: _____	_____
☐ End Of Year	☐ End Of Year
☐ End Of Month	☐ End Of Month

OTHER

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Two Persons	
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP

HEALTH INSURANCE PLAN OF GREATER NEW YORK

☐ HIP CLASSIC for SMALL GROUPS (2-50 Employees)

Group Name .....

COPAYMENT OPTIONS (Select One from each category)

PCP Office Visit / Specialist Office Visit Copayments:
- ☐ $5 / $5
- ☐ $10 / $10
- ☐ $15 / $15
- ☐ $20 / $20

Ambulatory Surgery Copayment:
- ☐ $0
- ☐ $50
- ☐ $75
- ☐ Other _____

Inpatient Facility Copayment:
- ☐ $0
- ☐ $250
- ☐ $500

Emergency Room Copayment:
- ☐ $35
- ☐ $50

OPTIONAL BENEFIT RIDERS

PRESCRIPTION DRUG OPTIONS

Generic/Brand/Non-Formulary Drug Copayments and Coinsurance

- ☐ $5 / $10 / 50%
- ☐ $10 / $15 / 50%
- ☐ $10 / $20 / 50%
- ☐ $100 Deductible $10 / $20 / 50%
- ☐ $5 / $10 / $35
- ☐ $10 / $15 / $35
- ☐ $10 / $20 / $35
- ☐ $100 Deductible $10 / $20 / $35
- ☐ No Prescription Drug Coverage
- ☐ Other _____

PRIVATE DUTY NURSING (Select One)

- ☐ Covered In Full
- ☐ Excluded

DURABLE MEDICAL EQUIPMENT (Select One)

- ☐ Covered In Full
- ☐ Excluded

OPTICAL (Select One)

- ☐ One pair eyeglasses every 12 months; $25 contact lens copayment
- ☐ One pair eyeglasses every 24 months; $25 contact lens copayment
- ☐ One pair eyeglasses every 12 months; $70 contact lens copayment
- ☐ One pair eyeglasses every 24 months; $70 contact lens copayment
- ☐ One pair eyeglasses every 24 months with $45 copayment
- ☐ One pair eyeglasses and contact lenses, covered up to a maximum of $75 every 12 months
- ☐ No Rider

ALTERNATIVE MEDICINE (Nutrition/Accupuncture/Massage)

- ☐ $25 Copay
- ☐ $20 Copay

FITNESS CENTER (Membership Reimbursement)

- ☐ $200

DEPENDENT COVERAGE (Select One from each column)

Full-Time Students	Dependent Children
☐ 23 End Of Year	☐ 19 End Of Month
☐ 25 End Of Year	☐ 23 End Of Year
	☐ 25 End Of Year

MONTHLY RATES (to be completed by your broker or HIP)

	4 TIER
Individual	$_____
Employee & Child(ren)	$_____
Employee & Spouse	$_____
Family	$_____

HIP® HIP HEALTH PLAN OF NEW YORK ▪ 55 WATER STREET, NEW YORK, NY 10041-8190

REQUEST FOR COVERAGE FOR A DEPENDENT CHILD WHO IS DISABLED DUE TO MENTAL ILLNESS, MENTAL RETARDATION, PHYSICAL HANDICAP OR DEVELOPMENTAL DISABILITY

Under the applicable provisions of The Insurance Law of New York State, a mentally retarded, mentally ill, physically handicapped, or developmentally disabled child will be considered a dependent under a family contract regardless of age, provided the child:

- Has not married
- Become mentally retarded, mentally ill, physically handicapped, developmentally disabled before reaching the age at which dependent coverage would otherwise terminate.
- Is incapable of self-sustaining employment and proof of such incapacity has been submitted within thirty-one days of such dependents attainment of the termination age.

Neither a reduction in work capability nor inability to find employment is, in itself, evidence of eligibility. If a mentally retarded, mentally ill, physically handicapped, and developmentally disabled child is working, the extent of his/her earning capacity will be evaluated. He/she must be chiefly dependent upon the subscriber for support and maintenance. A child who is continued as a dependent under a family contract is eligible for all the benefits of that contract.

<table>
<tr><th colspan="5">SECTION 1 TO BE COMPLETED BY SUBSCRIBER</th></tr>
<tr><td>Name of Subscriber</td><td colspan="3">Name of Dependent Child</td><td>HIP Number</td></tr>
<tr><td rowspan="2">Address of Subscriber</td><td colspan="3">Dependent's Date of Birth</td><td rowspan="2">Dependent's Marital Status:
Γ SINGLE Γ WIDOWED
Γ MARRIED Γ DIVORCED</td></tr>
<tr><td>Month</td><td>Day</td><td>Year</td></tr>
<tr><td colspan="2">Was Dependent Child Ever Institutionalized?

Γ NO
Γ YES</td><td colspan="2"></td><td rowspan="2">Period of Confinement:

From: To:</td></tr>
<tr><td colspan="4">If YES give Name & Address if Institution(s)</td></tr>
<tr><td colspan="4">Was Dependent Child Ever Employed for Wages?
Γ NO
Γ YES</td><td rowspan="2">Average Weekly Earnings

$</td></tr>
<tr><td colspan="4">If YES give Name/Address of Current or Last Employer.</td></tr>
<tr><td colspan="4">Signature of Parent or Legal Guardian</td><td>Date Signed</td></tr>
</table>

Subscriber Name: _____ **HIP #** _____

SECTION 2 TO BE COMPLETED BY PHYSICIAN		
REQUEST FOR MEDICAL INFORMATION		
In order to continue providing benefits to your patient we need to request a brief summary of the disabling clinical condition. Please respond briefly to the following:		
Is dependent presently incapable of self-sustaining employment by reason of: Γ MENTAL RETARDATION Γ MENTAL ILLNESS Γ PHYSICAL HANDICAP Γ DEVELOPMENTAL DISABILITY	Is incapacity congenital? Γ NO Γ YES	When did incapacity occur: Month: Year:
DIAGNOSIS OF CONDITION CAUSING HANDICAPPED STATUS**. IMPORTANT: PLEASE INCLUDE I.Q. OF DEPENDENT WORK ABILITY AND EDUCATIONAL STATUS. IF ACCIDENT, DATE OF ACCIDENT:**		
IN YOUR OPINION WILL THIS CHILD EVER BE CAPABLE OF SELF-SUSTAINING EMPLOYMENT? Γ NO Γ YES		
If the answer is YES how soon may he/she be self-sustaining?		
1. Brief history of disability:		
2. Pertinent clinical features:		
3. Relevant laboratory and other test results:		
4. Diagnosis:		
5. Current therapy, including special schooling or other rehabilitative services:		
6. Present physical and/or mental disability, expected degree of recovery (full or partial with estimated degree of handicap):		
7. Expected future gainful employability:		
Signature of attending M.D.	Date Signed	
Address		

FOR HIP USE ONLY

Approved By	Date	Date For Future Review
Rejected By	Date	

REFUSAL OF HIP INSURANCE FORM

FOR SMALL BUSINESSES WITH FEWER THAN 51 ELIGIBLE EMPLOYEES

(*Please Print*)

Group Policy Number: _____

Name of Employer: _____

Employee's Name: _____
(Last, First, MI)

Social Security Number: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widower

Number of Eligible Dependent Children: _____

I was given the opportunity to enroll in a group insurance plan offered by my employer and insured by HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.
I am refusing:
(**Note:** *Benefits provided on a noncontributory basis cannot be refused.*)

HIP/HMO:	**Choice Plus:**
❑ Employee & Dependents	❑ Employee & Dependents
❑ Spouse	❑ Spouse
❑ Child(ren)	❑ Child(ren)

ANSWER IF YOU ARE REFUSING ANY COVERAGE:
Are you or your dependents now covered by any other group plan? ❑Yes ❑No

If yes,
Policyholder's Name: _____

Carrier: _____

I understand that I may be required to furnish, at my expense, EVIDENCE OF INSURABILITY satisfactory to HIP Health Plan of New York and HIP Insurance Company of New York if I later wish to enroll for any of the coverages refused.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date

HIP Subscriber/Member Enrollment Form

Last Name	First Name	M.I.	Sex	Social Security Number

Street Address	Apt.	City	State	Zip Code

Were you ever a member of HIP? ☐ NO ☐ YES
If yes, indicate policy number(s): ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced

Birth Date: Mo. | Day | Yr.

Telephone #: Home: (____) ____________ Work: (____) ____________
E-Mail Address: ____________________

Primary Care Physician: (*not required for EPO/PPO members*)
Physician Name ____________
Physician ID Number ____________

OB/GYN Selection: (*Optional*)
Physician Name ____________
Physician ID Number ____________

Prior Health Insurance Information
Carrier Name ____________________
Coverage Begin Date __/__/__ Coverage End Date __/__/__

Qualifying Event: ☐ Birth/Adoption ☐ Marriage ☐ Loss of Coverage ☐ New Hire ☐ ____________ **Qualifying Event Date:** Mo.____ Day____ Yr.

Are you covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co. Name: ____________________
Insurance Co. Telephone #: ____________________
Type of Coverage: ____________________
Policy #: ____________ Effective Date: ___ / ___ / ___

Is your spouse covered by any other Health Insurance or Medicare?
☐ NO ☐ YES If yes, indicate:
Insurance Co. Name: ____________________
Insurance Co. Telephone #: ____________________
Type of Coverage: ____________________
Policy #: ____________ Effective Date: ___ / ___ / ___

**** If you are enrolling for your spouse and/or children, please list each one below – see Election of Coverage for eligibility***

Last Name (if different) / First Name	Soc. Sec. No.	Sex	Relationship	Birth Date (Mo. / Day / Yr.)	Check if disabled	Primary Care Physician Name/Number (*not required for EPO/PPO members*)	OB/GYN Selection Name/Number (*Optional*)
SPOUSE	_ _ _ - _ _ - _ _ _ _		☐ Wife ☐ Husband ☐ Other				
Prior Health Insurance Information	Carrier Name ____________		Coverage Begin Date__/__/__	Coverage End Date __/__/__			
ADDITIONAL DEPENDENTS (List oldest first)	_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter				
Prior Health Insurance Information	Carrier Name ____________		Coverage Begin Date__/__/__	Coverage End Date __/__/__			
	_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter				
Prior Health Insurance Information	Carrier Name ____________		Coverage Begin Date__/__/__	Coverage End Date __/__/__			
	_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter				
Prior Health Insurance Information	Carrier Name ____________		Coverage Begin Date__/__/__	Coverage End Date __/__/__			
	_ _ _ - _ _ - _ _ _ _		☐ Son ☐ Daughter				
Prior Health Insurance Information	Carrier Name ____________		Coverage Begin Date__/__/__	Coverage End Date __/__/__			

Your signature is required to process this form. Your signature attests that you have read the reverse side of this form

Applicant must sign here: ____________________ **Date**____________

THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group	Group Number

Select One: ☐ HIP PRIME HMO ☐ HIP*access* I ☐ HIP PRIME EPO ☐ HIP PRIME POS ☐ HIP*access* II ☐ HIP PRIME PPO ☐ HIP SELECT EPO ☐ HIP SELECT PPO ☐ HIP CLASSIC HMO

Requested Effective Date	Hire Date	Employee Title	Date Submitted to HIP	Approved by (*Representative of Benefits Administrator*)

Type of Coverage: ☐ Individual ☐ Family ☐ Employee & Spouse ☐ Employee & Child

Instructions to Benefit Administrators or Group Representatives: For Groups with 50 employees or less, you **MUST** complete Section A on the reverse side of this form. Required documentation MUST be attached to this Enrollment Form to be processed.

FOR HIP USE ONLY

PROCESSED BY	RECEIVED DATE	PROCESSED DATE

ELECTION OF COVERAGE

I am enrolling for coverage for myself, my spouse and unmarried children under the age limit shown on the group schedule of benefits who are full time students at an accredited educational institution and who are dependent on me and/or my spouse for support.

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and to remit same to HIP.

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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

HIP PRIME POS and HIP*access* II applicants please note that your benefits are provided under two separate contracts: a HIP, HMO contract issued by the Health Insurance Plan of Greater New York and HIP PRIME POS and HIP*access* II contract issued by the HIP Insurance Company of New York. Both contracts will end simultaneously if your HIP PRIME POS or HIP*access* II coverage ends.

The following paragraph pertains to small business groups only.

I understand that pre-existing conditions will not be covered during the first 12 months of my enrollment under my group's contract. A pre-existing condition is a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a pre-existing condition and genetic information may not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such genetic information. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions and any previous coverage I had. Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from my effective date under my group's contract.

SECTION A — DOCUMENTATION BASED ON GROUP SIZE

(To be completed by Benefits Administrator)

Group Type (Check One) →

ACTION **Check (✔)One**	Qualifying Event	Documentation Required	☐ Sole Proprietorship or One Subscriber Group	☐ Association of Two or More Employees	☐ Small Group - Less Than 50 Employees
☐ Add Subscriber	New Hire **or** Change in Plan	For eligible employees who work more than 20 hours weekly provide a recent Copy of NYS45 showing this subscriber as an employee **or** copy of Payroll documentation reflecting the date, employee's name and Social Security # **and** the employee's current year W4 form.	Not Eligible		
☐ Add Spouse	Marriage	Marriage Certificate			
☐ Add Dependent	Birth	☐ Birth Certificate or			
	Adoption	☐ Formal Adoption Papers or			
		☐ Court Approved Guardianship Papers			
☐ Add Spouse ☐ Add Dependent	Loss of Coverage				
		Certificate of Creditable Coverage			

Note: *No Retroactive Enrollments will be allowed. Members must be enrolled within 30 days from the Qualifying Event.*

HIP®
HEALTH PLAN OF NEW YORK

Transmittal Sheet

For reporting changes and terminations only

Please use separate form for Medicare enrollees.	Page of Pages	Transmittal No. (HIP use only)

Employer Group Number	Line of Business Rider	Prepared by	Title	Date of preparation

Employer Group Name and Address	**Return completed copies to:**
	HIP HEALTH PLAN OF NEW YORK **ENROLLMENT DEPARTMENT** P.O. Box 2806 NEW YORK, NY 10116-2806

To be completed by employer or agent				**For HIP use only**								Remarks
1. HIP I.D. Number	2. Name of Subscriber Last First M.I.	*3. Type of change or termination	4. Date of Effect change or termination	Contract Class Out 1	Out 2	Out 3	Out 4	In 1	In 2	In 3	In 4	
	1											
	2											
	3											
	4											
	5											
	6											
	7											
	8											
	9											
	10											
	11											
	12											
	13											
	14											
	15											

For HIP use only – Summary of Decreases and Increases

Processed by	Effective date	In-Area contract class Out 1	Out 2	Out 3	In 1	In 2	In 3	Out-Area contract class Out 1	Out 2	Out 3	In 1	In 2	In 3	Premium Adjustments
Registrar														
Accounting														

Use the following codes to indicate type of transaction in Column 3

Change –
11=Increase in Coverage
16=Reinstatement - No Break in Coverage
18=COBRA 18 Months Coverage
30=Renewal with Break in Coverage
36=COBRA 36 Months Coverage

Termination –
57=Resignation of Subscriber from Group
71=Deceased
72=Member Non-Payment of Premium
80=Transfer to ANother Plan or Carrier
84=Out of Service Area
88=Dissatisfied with Medical Service - Member
94=Dissatisfied with Medical Service - Group
97=Dissatisfied with HIP Administrative Services - Member
98=Dissatisfied with HIP Administrative Services - Group

Student Recertification

IMPORTANT! Failure to complete this form and return it to HIP Health Plan of New York within thirty-one (31) days from the date you were contacted for the student and/or disability information will result in the termination of coverage for this dependent.

HIP

Subscriber Attestation:

Full-time student? ____ Yes ____ No

Is this dependent handicapped? ____ Yes ____ No

Name of student**:** _____

Date of birth: _____

Name of accredited institution of learning that dependent is attending as a full-time student:

_____

Address of accredited institution of learning:

_____

_____

Phone number: ( ) _____- _____

Semester(s) attending: _____

Insured subscriber's name: _____

Insured subscriber's employer ID: _____ Insured subscriber's group type: _____

Insured subscriber's ID number: _____ Student's ID number: _____

Authorization:

I hereby request that the dependent named above remain covered on my health insurance policy. I certify that this dependent is an unmarried child currently attending an accredited educational institution. I certify that under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I understand that any person who knowingly and with the 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 civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.

Signature of subscriber: _____ Date: _____/_____/_____

Print name: _____

Return this form to the Enrollment Department at:
HIP Health Plan of New York, P.O. Box 2794, New York, NY 10117-3255

HIP Health Plan of New York

Introducing Domestic Partner Coverage for all HIP Small Groups

HIP is pleased to announce that we are now offering Domestic Partner Coverage (DPC) for same-sex and opposite-sex couples.* This coverage is available to all small groups with 2-50 employees.

DPC is available for all tier structures and for HIP's entire array of HMO, POS, EPO and PPO plans, within both the Prime and Premium networks. (Note: this DPC benefit does not affect 2007 rates).

In order to qualify for coverage under the rider, the subscriber must submit proof of DPC status. This includes proof of joint responsibility for common welfare and financial obligations, as well as cohabitation and Domestic Partner Registration. Some examples of acceptable items of proof of economic interdependency are:

- A joint mortgage or lease
- Evidence of joint responsibility for child care
- Joint wills, or a will designating the Domestic Partner as executor and/or primary beneficiary
- Ownership of a joint bank account, joint credit card, motor vehicle, or other major item of personal property.

For more information about this benefit for small groups, or for a full list of the requirements necessary to establish this benefit coverage, please contact your HIP representative or call our customer support staff at **1-888-447-7599**.

*DPC coverage is not available to sole proprietors.

Now that's HIP® HEALTH PLAN OF NEW YORK

hipusa.com®
English, Spanish, Chinese and Korean

Form to complete the transfer of your mail-order prescription refills

Member Information

Member ID Number: _____

Group: _____

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Evening telephone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Shipping address if different from your mailing address

Check if ☐ Temporary ☐ Permanent

_____

_____

_____

I understand the information I provide may be released to and used by my health plan in connection with the benefit plan programs. Information may be used for other reporting and analysis purposes without identification of me or my family members.

Signature X _____

Information Required for Each Refill Order (be sure to include a refill slip for each refill you order)

Patient name	Patient's Relation to plan member	Sex	Birth Date	Doctor name and phone number	Drug name/ Strength	Current Prescription #
1	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
2	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			
3	☐ Self ☐ Spouse ☐ Dependent	☐ M ☐ F	MM/DD/YYYY / /			

Payment Information

Please choose a form of payment:

☐ Money Order

☐ Check (Make payable to Medco)

☐ MC ☐ VISA® ☐ AMEX ☐ Diner's Club® ☐ Disc/NOVUS®

Total Refill Prescriptions Enclosed: ☐

Total Dollar Amount Enclosed: **$** ☐
(please do not send cash)

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
Credit Card Number

M ☐☐ Y ☐☐ **X** _____
Expiration Date Cardholder's Signature

☐ **If you would like us to retain this credit card to conveniently charge all future orders to it, please place a check mark in this box.**

MEDCO HEALTH SOLUTIONS OF FAIRFIELD
P O BOX 747000
CINCINNATI OH 45274-7000

FORM #TPROF16

It's easy to transfer your mail-order prescription refills to *Medco By Mail.*

Thank you for choosing **Medco By Mail** for convenient delivery of your long-term medications. We are happy to assist you in transferring refills for your current prescription from your previous mail-order pharmacy to Medco By Mail.

No new prescription is needed if you have refills left on your current one.

To complete the transfer of your prescription(s) to Medco By Mail, choose one of the three easy methods listed below. Please have your member ID number on hand before you begin, along with the prescription number from a current mail-order prescription label or refill slip. Please start the transfer when you have a 2-week supply of medication.

On-line

- Visit **www.medco.com**.
- Activate your account by registering with your Medco member ID number and a recent prescription number from your previous mail-order pharmacy.
- Click on "Order status" and follow the instructions for refilling your prescriptions.

By telephone

- Call the toll-free Member Services telephone number located on your member ID card or other plan materials.
- Use our automated phone system to request your prescription transfer. If you need help, you will be transferred to a Member Services representative.

By mail

- Fill out the information on the other side of this form.
- Attach your most recent refill slip(s) in the space indicated.
- Use the included Medco By Mail Order Center envelope to mail us the completed form and your mail-order co-payment.

Please note that prescriptions for certain controlled substances and compound medications cannot be transferred. You will need to obtain a new prescription from your doctor for these types of medications. There may also be some situations when this transfer process will not be successful and you will need to request a new prescription from your doctor. If you request a refill that cannot be transferred, Medco will notify you to contact your doctor.

We look forward to assisting you with your prescription needs

Please affix your current refill slip(s) for each prescription in the space provided. Without a refill slip your request cannot be processed. **Your medication will be sent to you via U.S. mail, usually within 8 days.**

Affix Refill Slip(s) Here

medco®

HIP
HEALTH PLAN OF NEW YORK

PHARMACY SERVICES
PRESCRIPTION DRUG CLAIM FORM

A. SUBSCRIBER INFORMATION

FOR OFFICE USE ONLY

Claim # _____

ID# _____ **Contract #** _____

Subscriber's Name _____
Last First MI

Street Address _____

City _____ State _____ Zip _____

SUBSCRIBER'S SIGNATURE: _____

B. PATIENT INFORMATION

Patient's Name _____
Last First MI

Date of Birth ____/____/____ (month / day / year) Male ____ Female ____ **Patient's ID #** _____

Patient's relationship to insured: Self ____ Spouse ____ Dependent ____

I certify that all Subscriber and Patient Information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to HIP and all necessary third parties for purposes of claims investigation and payment, utilization review and audit.

PATIENT'S SIGNATURE: _____

C. PHARMACY INFORMATION

NABP# _____ Tel # _____ (area code)

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ Zip _____

I certify that the prescription(s) listed below were lawfully dispensed for the above-named patient, information provided is correct and all supporting document is available for audit.

PHARMACIST'S SIGNATURE: _____

D1. PRESCRIPTION INFORMATION

Date Dispensed ____/____/____ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D2. PRESCRIPTION INFORMATION

Date Dispensed ____/____/____ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D3. PRESCRIPTION INFORMATION

Date Dispensed ____/____/____ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

D4. PRESCRIPTION INFORMATION

Date Dispensed ____/____/____ (mo dy yr) **Rx#:** _____ **New or Refill** (circle one) Name of Medication: _____

NDC# _____ Quantity Dispensed: _____ Days Supply: _____ Strength: _____

Prescriber's Name: _____ **Prescriber's State License #** _____

Presription Cost $ _____.

HIP®

HEALTH PLAN OF NEW YORK
55 WATER STREET • NEW YORK, NY 10041

DOC No. (To be entered by HIP)

Patient's Statement

CLAIM FORM FOR PHYSICIAN SERVICES

INSTRUCTIONS: This side of the form is to be filled out by you. Then send the form to the physician, so that he or she can fill out the reverse side and return it to us.

- **HIP VIP:** Do NOT file claim with Medicare; follow above instructions
- **MEDICARE MEMBERS:** Explanation of Medicare Benefits statement must accompany this form.

All questions must be complete. Incomplete forms will be returned.

HIP No. (Patient)		1. INSURED'S HIP NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle initial)	2. PATIENT'S BIRTH DATE MM DD YY / SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	2. INSURED'S ADDRESS (No. Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full time Student ☐ Part time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	8. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) Yes ☐ No ☐	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? Yes ☐ No ☐ PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? Yes ☐ No ☐	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes*** return to and complete item 9 a-d

12. Please describe the circumstance that made it necessary for you to receive the medical care for which you are claiming benefits.

13. I hereby authorize and direct any Physician, Hospital or Medical provider who rendered service to me for any illness or injury, to release to the Health Insurance Plan of Greater New York any information acquired during the course of such examination or treatment. I also consent to the disclosure of this claim to the medical provider by the Health Insurance Plan of Greater New York of anything related to my claim.

A photocopy of this authorization will be valid as the original.

Signature of Patient or authorized agent _____ Date _____

14. I authorize payment directly to the physician who signed the reverse side of this claim form.

Signature of Patient or authorized agent _____ Date _____

IMPORTANT: The reverse side is to be filled out by the physician

HIP®

HEALTH PLAN OF NEW YORK
55 WATER STREET • NEW YORK, NY 10041

Physician's Statement

Place of Service Codes:

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room — Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Center
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance — Land
42 Ambulance — Air or Water
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility
00 Other Vehicle

Type of Service Codes:

1 Primary Surgery
2 Assistant Surgery
3 Single Patient in Nursing Home/SNF
4 Anesthesia
5 Radiology
6 In Hospital Medical Care
7 Medical Care
8 Pathology
9 Outpatient Consultation
0 Medical Diagnostic Testing
10 Emergency Care
12 Hospice
14 Dental
16 Physical Therapy
18 Speech Therapy
20 Occupational Therapy
22 Home Health Care
24 Nursing
26 Termination of Pregnancy
28 Psychiatric Care
30 Alcohol Detox
32 Alcohol Rehab
34 Drug Detox
36 Drug Rehab
38 Dialysis
40 Transportation
42 Optical

A Ambulance
B Drugs and Biologicals
C Blood
D Professional Component
E Physician Assistant, In Hospital Care
F Physician Assistant, Other than Hospital Care
G Physician Asst Assist at Surgery
H Home Consultation
K Office Consultation
M DME Maintenance
N Wholesale Supplies, Nursing Home
P DME Purchase, New Equipment
R DME Rental
S Supplies
T Technical Component
U DME Purchase, Used Equipment
W Hospital Consultation
Z Ambulatory Surgery

HIP No. (Patient) | | | | | | | | | | - | | | | - | | |

1. INSURED'S HIP NUMBER

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

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

4. INSURED'S NAME (Last Name, First Name, Middle initial)

5. DATE OF CURRENT ILLNESS (First Symptom) OR MM DD YY INJURY (Accident) OR PREGNANCY (LMP)

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

7. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

8. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

9. LICENSE/UPN # OF REFERRING PHYSICIAN

10. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 5,6,7 OR 8 TO ITEM 14E BY LINE →

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

12.. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

13. PRIOR AUTHORIZATION NUMBER

14 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	14 B Place of Service	14 C Type of Service	14 D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	14 E DIAGNOSIS CODE	14 F $ CHARGES	14 G - MEDICAL SERVICES Fully Describe Procedures

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

16. PATIENT'S ACCOUNT NO.

17. ACCEPT ASSIGNMENT. YES ☐ NO ☐

18. TOTAL CHARGES $

19. AMOUNT PAID $

20. BALANCE DUE $

21. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill are made a part thereof).

SIGNED DATE

22. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).

23. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS ZIP, CODE & PHONE NUMBER.

LICENSE # GRP#

PLEASE PRINT OR TYPE

ADA Dental Claim Form

HIP®
HEALTH PLAN OF NEW YORK

Healthplex/HIP
P.O. Box 249
Hempstead, NY 11551-0249

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient' s Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

ADA

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

General Instructions

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

Coordination of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

National Provider Identifier (NPI)

49 and 54 NPI (National Provider Identifier): This is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Web site: **www.ada.org/goto/npi**.

Additional Provider Identifier

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.

Provider Specialty Codes

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's Web site at:
www.ada.org/goto/dentalcode