

EMPLOYER: \_\_\_\_\_

CLAIM NO. \_\_\_\_\_



***Island 65 Health Plan***

**3 TOILSOME LANE  
EAST HAMPTON, NEW YORK 11937  
(631) 324-2306 or (800) 926-2306**

TO BE COMPLETED BY THE INSURED (RETIREEE)

1. Patient's Name: \_\_\_\_\_  
first name middle initial last name

2. Patient's Address: \_\_\_\_\_  
street  
\_\_\_\_\_ city state zip code

3. Patient's Date of Birth: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

4. Patient's Sex:  Male  Female

5. Patient's Relationship to Employee:  Self  Spouse  Child  Other

6. Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

7. Insured's Name: \_\_\_\_\_

8. Insured's Address: \_\_\_\_\_  
\_\_\_\_\_

9. Is this condition related to an auto accident?  Yes  No

10. I authorized the release of any medical information necessary to process this claim.

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
Date

**11. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED HERE.**

\_\_\_\_\_ YES \_\_\_\_\_ NO

\_\_\_\_\_  
(SIGNATURE)

**PLEASE ATTACH THE MEDICARE EXPLANATION OF BENEFITS FOR EACH BILL SUBMITTED WITH A COPY OF THE PHYSICIAN OR HOSPITAL BILLING.**

PLEASE SEND THIS CLAIM FORM, COPIES OF YOUR MEDICARE EXPLANATION OF  
MEDICARE BENEFITS AND COPIES OF THE MATCHING BILLS TO:

*Island 65 Health Plan*

3 TOILSOME LANE

EAST HAMPTON, NEW YORK 11937

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL:

(631) 324-2306 LOCAL NUMBER

1(800) 926-2306 OUT OF AREA NUMBER

