Health Claim Transmittal

UnitedHealthcare
A UnitedHealth Group Company

A. GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Please clip (do not staple) all bills to the completed from and mail them to UnitedHealthcare at the address listed on your ID card.
- Please make sure all bills include a diagnosis code, procedure code, date of service, place of service, and cost.
- Please submit all claims to UnitedHealthcare in a timely manner.
- Please notify your employer of address changes.
- Please include your Subscriber Number or Social Security Number on all documents.

B. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or SSN: – –		Phone # ( )	
Employer Name:		Group Number (on ID card):	
Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:			New Address? Yes □ No □
City:		State:	ZIP Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth / /

C. PATIENT INFORMATION (if different from Subscriber/Employee)

Subscriber # or SSN: – –			Phone #: ( )	
Last Name:	First Name:		MI:	Date of Birth: / /
Home Address:				New Address? Yes □ No □
City:			State:	ZIP Code:
Sex: M □ F□	Relationship to Subscriber:	Full Time Student: Yes □ No □	School Name:	School Phone: ( )

D. ACCIDENT INFORMATION

Work Accident: Yes □ No□	Auto Accident: Yes □ No □	Other: Yes □ No □	Date of Accident: / /
How did the accident happen?			

E. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes □ No □ If yes, please complete the following information.		
Name of person carrying other insurance:		Date of Birth: / /
SSN: – –	Name of Other Insurance Carrier:	
Policy Number:	Employer Name:	

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Signature _____ Date (mm/dd/yyyy) _____

F. Assignment of Benefits

Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of medical services.

Signature _____ Date (mm/dd/yyyy) _____