BARCODE SPACE HERE

HEALTH CLAIM TRANSMITTAL

UnitedHealthcare®
A UnitedHealth Group Company

Employer Name
Group (policy) ***Number***

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber# or SSN: — —		Phone #: ( )	
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: / /

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /		
Home Address:					
City:	State:		Zip Code:		
Sex: M ☐ F ☐	Relationship to Subscriber:	Full Time Student: Yes ☐ No ☐	School Name:	School Phone #: ( )	

C. ACCIDENT INFORMATION

Work Accident: Yes ☐ No ☐	Auto Accident: Yes ☐ No ☐	Date Accident Occurred: / /
How did the accident occur?		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes ☐ No ☐ If yes, please complete the following:	
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.

Subscriber Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

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

Subscriber Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address listed on your ID card.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Subscriber# or SSN on all documents.