HEALTH CLAIM TRANSMITTAL

UnitedHealthcare®
A UnitedHealth Group Company

P.O. BOX 740800
ATLANTA, GA 30374-0800

A. MEMBER/EMPLOYEE INFORMATION

Member # (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 Member:	Full Time Student: Yes ☐ No ☐	School Name:		School Phone #: ( )

C. ACCIDENT INFORMATION

Work Accident? Yes ☐ No ☐	Auto Accident? Yes ☐ No ☐	Date Accident Occured: / /
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.

Member Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

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

Member 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 above.
- 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 Member Number on all documents.