UnitedHealthcare®
A UnitedHealth Group Company

P.O. Box 30555
Salt Lake City, UT 84130-0555

Health Claim Transmittal

Employee Name:_____ SSN: _____-____-_____ Date of Birth: ___/___/___

Employee Address:_____ Check If New Address | |

Employee Phone Number: (___)_____ Status: Active Continued (COBRA)
Area Code Number

Spouse Name: _____Spouse Date of Birth: ___/___/___

Patient Name: _____Date of Birth: ___/___/___ Relationship: _____

Nature of Illness of Injury: _____
_____
IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED

Do You Have Coverage Through Another Employer? Yes No

Is Your Spouse Employed? Yes No Is Patient Employed? Yes No

If you answered "yes" to any of the above questions, please provide the following information:
Employed Person: _____ Social Security Number: _____-____-_____

Employer: _____

Employer Address: _____ Phone Number (___)_____
Area Code Number

Insurance Company & Policy Number: **708611**

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OR 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.

Employee Signature: _____ Date: ____/___/_____

HINTS FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- ***If you want United HealthCare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).***
- *Attach your bills to this completed form and mail them to United HealthCare at the address shown above. COBRA continuees mail this to the United HealthCare claim office you used as an active employee (or as a dependent of an active employee).*
- *Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.*
- *Send additional bills periodically or when they total $50.00 or more.*

FOR UNITED HEALTHCARE USE ONLY

DATE BENEFITS BECAME EFFECTIVE
DATE BENEFITS TERMINATED
SUFFIX ACCOUNT

SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:

DATE: