Medical Claim Form

What is this form for?

This form is for out-of-network claims ONLY, to ask for payment for eligible health care you have received.

To ensure faster processing of your claim, be sure to do the following:

If you write on the form, use black or blue ink and print clearly and legibly. You can also use your computer to complete this form and then print it out to mail it to us. Complete all of the applicable fields on the form. Ask your provider for the Provider Information, or have them fill that out for you. Be sure to submit a separate form for each claim.

If you have other insurance or Medicare and it is primary to your UnitedHealthcare plan, please include the explanation of benefits (EOB) from your other insurance or Medicare.

Ask your provider to complete the Provider Information section on the form (below). All of the information in that section is required to process the claim.

Ask your provider to give you a Superbill or Invoice that includes all of the following for each date of service:

IMPORTANT: This information must be on the Superbill as it is required to process the claim. Missing information can result in a delay or non-payment of the claim. Please be sure the information is clear and readable.

- Patient Name
- Diagnosis codes. [Claims with date of service after October 1, 2016 must be ICD10].
- Procedure Codes (CPT, HCPC) - with any applicable modifiers.
- Units for each procedure code.
- The billed amount for each procedure code.
- Place of service code.

How to get the maximum benefit:

Use a participating provider to receive the maximum benefit. Durable medical equipment and ongoing services such as physical therapy are especially cost effective with a UnitedHealthcare provider.

Please review your benefits at **myuhc.com**. For services that require prior authorization or notification, be sure to call the Member Services number on the back of your health plan ID card.

What happens next:

After we process your claim, we will send you an Explanation of Benefits (EOB). The EOB will explain the charges applied to your plan deductible and any charges you owe your health care provider. Please keep your EOB on file for future reference. You also may review your EOB information online at myuhc.com.

Once you have completed the form, mail it to the address listed on the back of your Health Plan ID Card.
Be sure to attach the Superbill or Invoice and any receipts of your payments.

UnitedHealthcare®

Member ID (from Health Plan ID card, can be up to 11 digits):

Group Number (can be 6 or 7 digits):

Patient Information.

Name (Last, First, MI):

Date of Birth: / /

Home Address:

Gender: ○ M ○ F

Relationship to Subscriber / Policyholder:
- ○ Subscriber/Policyholder
- ○ Spouse/Partner
- ○ Child
- ○ Other Dependent

City: **State:** **ZIP Code:**

New Address?: ○ Yes ○ No

Phone #: ( ) –

Policyholder Information. (Complete this section only if it is different than the patient information.)

Employee Name (Last, First, MI):

Phone #: ( ) –

Home Address:

Date of Birth: / /

City: **State:** **ZIP Code:**

New Address?: ○ Yes ○ No

Provider Information. This information is required to process the claim. Ask your provider for this information or have them fill it out for you.

Provider (or Rendering Provider) Name:

Provider Tax Identification Number:

NPI Number:

Group/Facility Name:

Provider Address:

Address where services were rendered:

City: **State:** **ZIP Code:**

Phone Number: ( ) –

Accident Information. (If applicable)

Date of Accident: / /

Type of Accident: ○ Work ○ Auto ○ Other

How did the accident happen?

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 (Last, First, MI):

Date of Birth (of person carrying other insurance): / /

Name of Other Insurance Carrier:

Policy Number:

Employer Name:

Effective date of Other Insurance: / /

Cancellation date of Other Insurance (if applicable): / /

Did you attach an EOB from Medicare or your other insurance?: ○ Yes ○ No

Assignment of Benefits.

☐ **Please check this box if you want UnitedHealthcare to pay benefits directly to the doctor/provider.**

By signing below, I am stating that the information above is correct. 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:** / /