



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.

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

11 digit grid for Member ID

Group Number (can be 6 or 7 digits):

6-7 digit grid for Group Number

Patient Information.

Name (Last, First, MI):

Home Address:

City, State, ZIP Code fields

Phone # field

Date of Birth:

Date of Birth grid

Gender: M F

New Address?: Yes No

Relationship to Subscriber / Policyholder:

- Subscriber/Policyholder
Spouse/Partner
Child
Other Dependent

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

Employee Name (Last, First, MI):

Home Address:

City, State, ZIP Code fields

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:

NPI Number:

Provider Address:

City, State, ZIP Code fields

Provider Tax Identification Number:

Group/Facility Name:

Address where services were rendered:

Phone Number field

Accident Information. (If applicable)

Date of Accident field

How did the accident happen?

Type of Accident: Work Auto Other

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):

Name of Other Insurance Carrier:

Policy Number:

Effective date of Other Insurance field

Cancellation date of Other Insurance field

Date of Birth (of person carrying other insurance):

Date of Birth grid

Employer Name:

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:

