

# Medical Claim Form

## What is this form for?

Use this UnitedHealthcare Claim Form to ask for payment for eligible care you've already received.



### Get your money back faster. Send your expenses online.

Online submissions allow for faster reimbursement, reduced errors and saved paper. Here's the process:

1. Log in to your member website.
2. Follow steps to instantly send an online claim form.

## Did you know?

You receive a higher benefit if you use a UnitedHealthcare provider. This can be especially cost effective when receiving ongoing services like physical therapy or when purchasing durable medical equipment.

## Things to Remember:

- Send the claim as soon as you can and as close to the date of service as possible. Most services must be submitted within 90 days of the date you received them. [For inpatient stays, the 90 days begins on the date your stay ended.]
- Be sure your member ID and the provider's or facilities details are clearly written on the claim. This will help you receive faster payment.
- Send a detailed claim of the services from your provider, not just a receipt of your payment. Details like service codes and diagnosis codes are needed to process your claims quickly and correctly.
- Make a copy of the claim form, claim details and receipt(s) to keep for your records.
- Mail your form with the claim details and receipt(s) to the address on the back of your health plan ID card.

## What happens next:

After processing your claim, you'll receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also review your EOB information on myuhc.com.

Member ID (from Health Plan ID card):

11 digit grid for Member ID

Group Number (from Health Plan ID card):

6 digit grid for Group Number

Patient Information

Name (Last, First, MI):

Line for Name

Date of Birth:

MM/DD/YYYY date grid

Home Address:

Line for Home Address

Gender:

- M, F radio buttons

Relationship to Subscriber / Policyholder:

- Subscriber/Policyholder, Spouse/Partner, Child, Other Dependent radio buttons

City:

Line for City

State:

2 digit state grid

ZIP Code:

5 digit ZIP code grid

New Address?:

- Yes, No radio buttons

Phone #:

( ) - phone number grid

Subscriber/Policyholder Information

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

Employee Name (Last, First, MI):

Line for Employee Name

Phone #:

( ) - phone number grid

Home Address:

Line for Home Address

Date of Birth:

MM/DD/YYYY date grid

City:

Line for City

State:

2 digit state grid

ZIP Code:

5 digit ZIP code grid

New Address?:

- Yes, No radio buttons

Provider Information

Provider Name:

Line for Provider Name

Provider Tax Identification #:

Provider Address:

Line for Provider Address

City:

Line for City

State:

2 digit state grid

ZIP Code:

5 digit ZIP code grid

Accident Information

Date of Accident:

MM/DD/YYYY date grid

Type of Accident: Work, Auto, Other radio buttons

How did the accident happen?

Two lines for accident description

Other Insurance

Is the patient covered by another insurance plan? Yes No radio buttons

(If yes, please complete the following information.)

Name of person carrying other insurance (Last, First, MI):

Line for Name

Date of Birth:

MM/DD/YYYY date grid

Name of Other Insurance Carrier:

Line for Carrier Name

Policy Number:

Line for Policy Number

Employer Name:

Line for Employer Name

Assignment of Benefits

Check box: 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: MM/DD/YYYY grid

