

**A. GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE**

- Please clip (do not staple) all bills to the completed form and mail them to UnitedHealthcare at the address listed on your ID card.
- Please make sure all bills include a diagnosis code, procedure code, date of service, place of service, and cost.
- Please submit all claims to UnitedHealthcare in a timely manner.
- Please notify your employer of address changes.
- Please include your Subscriber Number or Social Security Number on all documents.

**B. SUBSCRIBER/EMPLOYEE INFORMATION**

Subscriber # or SSN:                    -                    -		Phone # (                    )	
Employer Name:		Group Number (on ID card):	
Last Name:	First Name:	MI:	Date of Birth:    /    /
Home Address:			New Address? Yes <input type="checkbox"/> No <input type="checkbox"/>
City:		State:	ZIP Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth /    /

**C. PATIENT INFORMATION (if different from Subscriber/Employee)**

Subscriber # or SSN:                    -                    -		Phone #: (                    )	
Last Name:	First Name:	MI:	Date of Birth:    /    /
Home Address:			New Address? Yes <input type="checkbox"/> No <input type="checkbox"/>
City:		State:	ZIP Code:
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Subscriber:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name:                    School Phone: (                    )

**D. ACCIDENT INFORMATION**

Work Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Other: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Accident:    /    /
How did the accident happen?			

**E. OTHER INSURANCE**

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following information.	
Name of person carrying other insurance:	Date of Birth:    /    /
SSN:                    -                    -	Name of Other Insurance Carrier:
Policy Number:	Employer Name:
<p>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.</p>	
_____ Signature	_____ Date (mm/dd/yyyy)

**F. Assignment of Benefits**

Please sign below only if you want UnitedHealthcare to pay benefits directly to the provider of medical services.	
_____ Signature	_____ Date (mm/dd/yyyy)