UnitedHealthcare Insurance Company

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland, ME 04112-7149
1-866-293-1794
Fax: 1-800-980-0298

NOTICE OF CLAIM – ACCELERATED BENEFITS

Employer: **1. Indicate patient's name on Part B, then forward to physician to complete.**

2. Upon return of Part B, complete Part A

3. Send immediately to UnitedHealthcare Insurance Company at the address indicated above, and retain a copy for your records.

PART A

Employer	Phone Number
Employer Address (No., Street, City, State, Zip Code)	
Policyholder Name (if different from Employer)	
Employee Name (Last, First, M.I.)	Employee Social Security #

Date Employed	Effective Date of Coverage	Class	Group	☐ Union ☐Non-Union ☐ Hourly ☐ Salary	Wage/Salary $

Policy Number(s)	Suffix	Account	Amount of Insurance	Effective Date of Present Amount of Insurance
			$	
			$	
			$	

Dollar Amount Requested: _____(up to the maximum amount as shown in the Accelerated Death Benefit in the Life Certificate of Coverage)

Has any part of this insurance been assigned? ☐ Yes ☐ No If yes, attached authorization form

Name (Last, First, M.I).	Social Security Number	Date of Birth
Address (No., Street, City, State, Zip Code)		
If Claim is for Employee: Date Last Worked	Date of Disability	

Any Person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law

EMPLOYEE:

(IMPORTANT): Sign your name the way you would sign a check)	Signature	Date

EMPLOYER:

Authorized by (please print)	Authorized Signature	Date

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Patient' Name

PART B - to be completed by Attending Physician

Completed form should be returned to Patient's employer

1. Diagnosis (including any complications)

Objective Findings

2. Is condition terminal
☐Yes ☐ No

Life expectancy_____

3. Is the Patient confined in a nursing home with the expectation to remain in the nursing home for the rest of the Patient's life?

☐Yes ☐ No Date of Confinement ____/____/____

4. Is this patient receiving continual home health care with the expectation that these services will be needed for the rest of his/her life?

☐Yes ☐ No Date of services first received ____/____/____

5. DATES OF TREATMENT
Date of first visit for this condition ____/____/____

Date of last visit ____/____/____

Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify_____)

Date of examination ____/____/____

6. Are you aware of any other treating physician?

☐Yes ☐ No
If yes, name and address_____

7. MENTAL COMPETENCY
Is the patient competent to endorse checks and direct the use of the proceeds thereof?

☐Yes ☐ No

PLEASE PRINT OR TYPE:

Doctor's Name	Specialty	Telephone Number

Mailing Address (No., Street, City, State, Zip Code

Physician's Signature	Date