# HEALTH CLAIM TRANSMITTAL

*Guidelines for submitting claims to UnitedHealthcare are listed at the bottom of this form.*

PO Box 30555
Salt Lake City, UT 84130

## A. MEMBER/EMPLOYEE INFORMATION

| Member # (SSN): — — | | | Phone #: ( ) |
|---|---|---|---|
| Last Name: | First Name: | MI: | Date of Birth: / / |
| Home Address: | | | New Address: Yes No |
| City: | State: | | Zip Code: |
| Spouse Last Name: | First Name: | MI: | Spouse Date of Birth: / / |

## B. PATIENT INFORMATION

| Last Name: | First Name: | MI: | Date of Birth: / / |
|---|---|---|---|
| Home Address: | | | |
| City: | State: | | Zip Code: |

| Sex: M F | Relationship to Member: | Full Time Student: Yes No | School Name: | School Phone #: ( ) |
|---|---|---|---|---|

## C. ACCIDENT INFORMATION

| Work Accident? Yes No | Auto Accident? Yes No | Date Accident Occured: / / |
|---|---|---|
| How did the accident occur: | | |

## D. OTHER INSURANCE

| Is the patient covered by another insurance plan? Yes No If yes, please complete the following: | |
|---|---|
| Name of person carrying other insurance: | Date of Birth: / / |
| SSN#: — — | Name of Other Insurance Carrier: |
| Policy Number: | Employer Name: |

**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.**

Member Signature: ______________________ Date: ______________________

## E. ASSIGNMENT OF BENEFITS

Please sign below *only if you want UnitedHealthcare to pay benefits directly to the provider* of medical services.

Member Signature: ______________________ Date: ______________________

## GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Member Number on all documents.