UNITEDhealthcare℠

P.O. Box 30555
Salt Lake City, UT 84130

United HealthCare
HEALTH CLAIM TRANSMITTAL

Employee Name: ______________________ SSN: ___–___–___ Date of Birth: ___/___/___

Employee Address: ______________________ Check If New Address ☐

Employee Phone Number: (______) ______________ Status: ☐ Active ☐ Retired ☐ Continued (COBRA)
Area Code Number

Spouse Name: ______________________ Spouse Date of Birth: ___/___/___

Patient Name: ______________ Patient Date of Birth: ___/___/___ Relationship: ______________

Nature of Illness or Injury: ______________________

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IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED

Do You Have More Than One Employer? Yes ☐ No ☐

Is Your Spouse Employed? Yes ☐ No ☐ Is Patient Employed? Yes ☐ No ☐

If you answered "yes" to any of the above questions, please provide the following information:

Employed Person: ______________________ Social Security Number: ___–___–___

Employer: ______________________

Employer Address: ______________________ Phone Number: (______) ______________
Area Code Number

Insurance Company & Policy Number: ______________________

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.

Employee Signature: ______________________ Date: ___/___/___

HINTS FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- **If you want United HealthCare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).**
- *Attach your bills to this completed form and mail them to United HealthCare at the address shown above.*
- *Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.*
- *Send additional bills periodically or when they total $50.00 or more.*

FOR UNITED HEALTHCARE USE ONLY

DATE BENEFITS BECAME EFFECTIVE		DATE BENEFITS TERMINATED		SUFFIX	ACCOUNT
MO. DAY YEAR	MO. DAY YEAR	MO. DAY YEAR	MO. DAY YEAR		
Emp.	Dep.	Emp .	Dep.		

SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:	DATE MO. DAY YEAR