Medical Claim Form

What is this form for?

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

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:

- Complete this form on your computer before printing it. You can also complete it by hand.
- Make a copy of this claim form, claim details and receipt(s) to keep for your records.
- Send the claim as soon as you can and as close to the date of service as possible. Most plans require that services 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 facility's details are clear and complete 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.
- 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.

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Member ID (from Health Plan ID card):

Group Number (from Health Plan ID card):

Patient Information

Name (Last, First, MI):

Date of Birth: / /

Home Address:

Gender:
- M
- F

Relationship to Subscriber / Policyholder:
- Subscriber/Policyholder
- Spouse/Partner
- Child
- Other Dependent

City:

State:

ZIP Code:

New Address?:
- Yes
- No

Phone #:
( ) –

Subscriber/Policyholder Information

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

Employee Name (Last, First, MI):

Phone #:
( ) –

Home Address:

Date of Birth: / /

City:

State:

ZIP Code:

New Address?:
- Yes
- No

Provider Information

Provider Name:

Provider Tax Identification #:

Provider Address:

City:

State:

ZIP Code:

Accident Information

Date of Accident: / /

Type of Accident: Work Auto Other

How did the accident happen?

Other Insurance

Is the patient covered by another insurance plan? Yes No (If yes, please complete the following information.)

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

Date of Birth: / /

Name of Other Insurance Carrier:

Policy Number:

Employer Name:

Assignment of Benefits

☐ 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: / /

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