Member ID (from Health Plan ID card, can be up to 11 digits):

Group Number (can be 6 or 7 digits):

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 #: (☐☐☐) ☐☐☐ – ☐☐☐☐

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. This information is required to process the claim. Ask your provider for this information or have them fill it out for you.

Provider (or Rendering Provider) Name:

Provider Tax Identification Number:

NPI Number:

Group/Facility Name:

Provider Address:

Address where services were rendered:

City: **State:** ☐☐ **ZIP Code:** ☐☐☐☐☐

Phone Number: (☐☐☐) ☐☐☐ – ☐☐☐☐

Accident Information. (If applicable)

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 (of person carrying other insurance): ☐☐ / ☐☐ / ☐☐☐☐

Name of Other Insurance Carrier:

Policy Number:

Employer Name:

Effective date of Other Insurance: ☐☐ / ☐☐ / ☐☐☐☐

Cancellation date of Other Insurance (if applicable): ☐☐ / ☐☐ / ☐☐☐☐

Did you attach an EOB from Medicare or your other insurance?: ○ Yes ● No

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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