Health Claim Transmittal

UnitedHealthcare
A UnitedHealth Group Company

A. GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Please clip (do not staple) all bills to the completed from and mail them to UnitedHealthcare at the address listed on your ID card.
- Please make sure all bills include a diagnosis code, procedure code, date of service, place of service, and cost.
- Please submit all claims to UnitedHealthcare in a timely manner. SEE ATTACHED SUPERBILL FROM SHAYA PRECISION HEALTH
- Please notify your employer of address changes.
- Please include your Subscriber Number or Social Security Number on all documents.

B. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or SSN: – –		Phone # ( )	
Employer Name:		Group Number (on ID card):	
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 / /

C. PATIENT INFORMATION (if different from Subscriber/Employee)

Subscriber # or SSN: – –			Phone #: ( )	
Last Name:	First Name:	MI:	Date of Birth: / /	
Home Address:			New Address? Yes □ No □	
City:			State:	ZIP Code:
Sex: M □ F□	Relationship to Subscriber:	Full Time Student: Yes □ No □	School Name:	School Phone: ( )

D. ACCIDENT INFORMATION

Work Accident: Yes □ No□	Auto Accident: Yes □ No □	Other: Yes □ No □	Date of Accident: / /
How did the accident happen?			

E. 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:		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.

Signature _____ Date (mm/dd/yyyy) _____

F. Assignment of Benefits

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

DO NOT SIGN HERE, PLEASE PAY PATIENT DIRECTLY

Signature _____ Date (mm/dd/yyyy) _____