

**HEALTH CLAIM TRANSMITTAL**

United Healthcare  
 PO Box 30555  
 Salt Lake City, UT 84130  
**UnitedHealthcare**<sup>®</sup>



**Employer Name** - City of Plano  
**Group** (policy) **Number** - 704335

**A. SUBSCRIBER/EMPLOYEE INFORMATION**

Subscriber # or SSN:                   —                   —		Phone #:                   (           )                   )	
Last Name:	First Name:	MI:	Date of Birth:                   /           /           /
Home Address:			New Address:   Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Subscriber:	Full Time Student:                   Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name:                   School Phone #:                   (           )                   )

**C. ACCIDENT INFORMATION**

Work Accident:   Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident:   Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred:                   /           /           /
How did the accident occur?		

**D. OTHER INSURANCE**

Is the patient covered by another insurance plan?   Yes <input type="checkbox"/> No <input type="checkbox"/> 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.**

Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**E. ASSIGNMENT OF BENEFITS**

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

Subscriber 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 listed on your ID card.
- 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 Subscriber # or SSN on all documents.