

**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: \_\_\_\_\_

**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 the completed form and mail them to United HealthCare at the address shown above. COBRA continues mail to the United HealthCare claim office you used as an active employee (or as a dependent of an active employee).*
- *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	YR	MO.	DAY	YR			
Emp.		Dep.	Emp.		Dep.			
SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:						DATE		
						MO.	DAY	YR