

**HEALTH CLAIM TRANSMITTAL**

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employee Address: \_\_\_\_\_ Check If  
New Address

Employee Phone Number: (\_\_\_\_) \_\_\_\_\_ Status: <sup>1</sup> Active <sup>1</sup> Retired <sup>1</sup> 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 <sup>1</sup> No <sup>1</sup>

Is Your Spouse Employed? Yes <sup>1</sup> No <sup>1</sup> Is Patient Employed? Yes <sup>1</sup> No <sup>1</sup>

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 this completed form and mail them to United Healthcare at the address shown above. COBRA continuees 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	YEAR	MO.	DAY	YEAR			MO.	DAY	YEAR	
Emp.			Dep.			Emp.			Dep.		
SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:							DATE (MO.   DAY   YEAR)				