REQUIREMENTS
FOR
NON-NETWORK PROVIDER CLAIMS

The following are tips in completing your claim form to help expedite the processing and payment of your claim in most cases.

- **Fill In All The Requested Information:** Any bill/ claim submitted to us requires your full name, address, ID number (usually your SSN) and your Employer's name and full address. Please provide the patient's full name, full address, DOB, Gender, and relationship to the insured member.

- **Use The HCFA-1500 Form:** We would prefer all claims to be submitted on the HCFA-1500 form.

- **Follow The Published Instructions:** The instructions for filling out the HCFA-1500 form can be found at http://www.cms.hhs.gov/manuals/14_car/3b4010.asp#_4020_0

- **Provide Additional Insurance Information:** If patient has medical coverage through any other insurance, we request that you please submit the Name and full address of the Insurance company, along with phone #, group #, etc.

- **Verify Patient Name and Covered Individual Have the Same Last Name:** If patient has a different last name and/ or over 19 years of age, we will request additional information be submitted in order to complete the processing of your claim.

- **Assignment of Benefits:** If signed, the member is authorizing the insurance company to pay his/ her benefits directly to the Provider of service. If you do not wish payment to go directly to the provider, please leave this line blank. If left blank, payment will automatically be paid to the member.

The following Provider billing information must be completed and can be obtained from your provider or the facility where you received treatment:

1. Diagnosis
2. Date(s) of service (break-down of charges per day for facility based treatment)
3. Place of Service (office or facility)
4. CPT code (description of services rendered by the Provider-procedure code that you can get from your provider)
5. Amount Charged (breakdown of charges per day for facilities; or cost of each visit for providers)

6. Provider Name & Address (actual provider who rendered the service and address of where the service was rendered)
7. Provider Tax ID or Social Security #, and Provider's license level (MFCC, PHD, MD, etc.).

Copy Completed Claim Form for your records.

Please send claim to:

UBH Claims
P.O. Box 30755
Salt Lake City, UT 84130-0755

If you have any questions, do not hesitate to contact Member Services at 1-800-445-9720 (Press 1, then 3 to speak to a Member Services Representative).