PricewaterhouseCoopers
Group # 752713
Member Services: (888) 792-1545

For Medical Claims:
PO Box 740809
Atlanta, GA 30374-0809
Fax #: (248) 733-6000

For Mental Health/Substance Use Claims:
PO Box 30760
Salt Lake City, UT 84130-0760
Fax #: (248) 733-6079

HEALTH CLAIM TRANSMITTAL

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber/Member #:		Phone #:	
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:

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth:	
Home Address:				
City:	State:		Zip Code:	
Sex: M ☐ F ☐	Relationship To subscriber:	Full Time Student: Yes ☐ No ☐	School Name:	School Phone #:

C. ACCIDENT INFORMATION

Work Accident? Yes ☐ No ☐	Auto Accident: Yes ☐ No ☐	Date Accident Occurred:
How did the Accident Occur:		

D. OTHER INSURANCE

Is the patient covered by another plan? Yes ☐ No ☐ If yes, please complete the following	
Name of the person carrying other insurance:	Date of Birth:
Member #:	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.

Member Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below *only if you want UnitedHealthcare to pay benefits directly to the provider* of medical/mental health/ substance abuse services.

Signature: _____ Date: _____

F. 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 at the address on top of this claim form.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Subscriber Number or Member Number on all documents.

Make sure that all bills include the following:

- Employee and Member information including address
- Patient and/or guardian name
- Diagnosis code from the provider
- Dates of Service – Each date of service should be specified
- Place of Service – Physician's Office, Outpatient Facility, etc.
- CPT Codes
- Billed amount
- Provider tax id number
- Claim total
- Name of provider
- Address where services were rendered
- Billing Address