Medical Claim Form

What is this form for?

Use this UnitedHealthcare Claim Form to ask for payment for eligible care you've already received.

Get your money back faster. Send your expenses online.

Online submissions allow for faster reimbursement, reduced errors and saved paper. Here's the process:

1. Log in to your member website.
2. Follow steps to instantly send an online claim form.

Did you know?

You receive a higher benefit if you use a UnitedHealthcare provider. This can be especially cost effective when receiving ongoing services like physical therapy or when purchasing durable medical equipment.

Things to Remember:

- Send the claim as soon as you can and as close to the date of service as possible. Most services must be submitted within 90 days of the date you received them. [For inpatient stays, the 90 days begins on the date your stay ended.]
- Be sure your member ID and the provider's or facilities details are clearly written on the claim. This will help you receive faster payment.
- Send a detailed claim of the services from your provider, not just a receipt of your payment. Details like service codes and diagnosis codes are needed to process your claims quickly and correctly.
- Make a copy of the claim form, claim details and receipt(s) to keep for your records.
- Mail your form with the claim details and receipt(s) to the address on the back of your health plan ID card.

What happens next:

After processing your claim, you'll receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also review your EOB information on myuhc.com.

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Member ID (from Health Plan ID card):

Group Number (from Health Plan ID card):

Patient Information

Name (Last, First, MI):

Date of Birth: ___ / ___ / ____

Home Address:

Gender:
- ○ M
- ○ F

Relationship to Subscriber / Policyholder:
- ○ Subscriber/Policyholder
- ○ Spouse/Partner
- ○ Child
- ○ Other Dependent

City:

State:

ZIP Code:

New Address?:
- ○ Yes
- ○ No

Phone #: (___) ___ – ____

Subscriber/Policyholder Information

(Complete this section only if it is different than the patient information.)

Employee Name (Last, First, MI):

Phone #: (___) ___ – ____

Home Address:

Date of Birth: ___ / ___ / ____

City:

State:

ZIP Code:

New Address?:
- ○ Yes
- ○ No

Provider Information

Provider Name:

Provider Tax Identification #:

Provider Address:

City:

State:

ZIP Code:

Accident Information

Date of Accident: ___ / ___ / ____

Type of Accident: ○ Work ○ Auto ○ Other

How did the accident happen?

Other Insurance

Is the patient covered by another insurance plan? ○ Yes ○ No (If yes, please complete the following information.)

Name of person carrying other insurance (Last, First, MI):

Date of Birth: ___ / ___ / ____

Name of Other Insurance Carrier:

Policy Number:

Employer Name:

Assignment of Benefits

☐ Please check this box if you want UnitedHealthcare to pay benefits directly to the doctor/provider.

By signing below, I am stating that the information above is correct. 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.

Signature: _____ Date: ___ / ___ / ____

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