Century Business Services
POLICY # 188335

UNITEDhealthcare℠

P.O. Box 30555
Salt Lake City, UT 84130-0555

HEALTH CLAIM TRANSMITTAL

Employee Name: _____ SSN: ___-___-____ Date of Birth: __/__/____

Employee Address: _____ Check If New Address ☐

Employee Phone Number: _(____)_____ Status: ¹ Active ¹ Retired ¹ 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 ¹ No ¹

Is Your Spouse Employed? Yes ¹ No ¹ Is Patient Employed? Yes ¹ No ¹

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 MO. DAY YEAR	DATE BENEFITS TERMINATED MO. DAY YEAR	SUFFIX	ACCOUNT
Emp. | | Dep. | |	Emp. | | Dep. | |		

SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:	DATE (MO. | DAY | YEAR)
	| |