

HEALTH CLAIM TRANSMITTAL

City of Lakeland
702586
Choice Plus: 866-633-2477
PPO: 866-230-5782



A. MEMBER/EMPLOYEE INFORMATION

Form section A containing fields for Member # (SSN), Phone #, Last Name, First Name, MI, Date of Birth, Home Address, City, State, Zip Code, Spouse Last Name, Spouse First Name, Spouse MI, Spouse Date of Birth.

B. PATIENT INFORMATION

Form section B containing fields for Last Name, First Name, MI, Date of Birth, Home Address, City, State, Zip Code, Sex (M/F), Relationship to Member, Full Time Student (Yes/No), School Name, School Phone #.

C. ACCIDENT INFORMATION

Form section C containing fields for Work Accident? (Yes/No), Auto Accident? (Yes/No), Date Accident Occurred, and How did the accident occur.

D. OTHER INSURANCE

Form section D containing fields for Is the patient covered by another insurance plan? (Yes/No), Name of person carrying other insurance, Date of Birth, SSN#, 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 services.

Member Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
• Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
• Submit all claims to UnitedHealthcare in a timely manner.
• Be sure to notify your employer of all address changes.
• Please include your Member Number on all documents.