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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