UnitedHealthcare®
Healing health care. Together.™

HEALTH CLAIM TRANSMITTAL

INSURED INFORMATION

Last Name:	First Name:	Middle Initial:

Student Insurance ID# or Social Security#:	Home phone #:	Birth date:
	( )	/ /

Street address:	P.O. box:	City:	State:	ZIP Code:

PATIENT INFORMATION (IF DIFFERENT FROM ABOVE)

Last Name:	First Name:	Middle Initial:
Street address:	City:	State:
P.O. box:	ZIP Code:	Birth date:

Patient's relationship to student:

❑ Self	❑ Spouse	❑ Child	❑ Other

ACCIDENT INFORMATION

❑ Work Accident:	❑ Auto Accident:	❑ Intercollegiate Sport Accident:	❑ Intramural Sport Accident:	❑ Interscholastic Sport Accident:
Date Occurred:		Type of Sport (ex: Football, etc.):		
Details of Accident:				

INJURY / SICKNESS INFORMATION

Have you suffered the same or a similar condition in the past?
❑ Yes ❑ No

If Yes, and if you were treated for it, please give the name and address of the physician who treated you.

Physician's Name:	Physician's Address:	Date Treated:

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER MEDICAL PROVIDER TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM TO UNITEDHEALTHCARE INSURANCE COMPANY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Insured's Signature:	**Date:**

OTHER INSURANCE INFORMATION

(If the patient is covered by another insurance plan, please complete the following.)

Name of person carrying other insurance:	Subscriber # or Social Security#:	Name of other insurance carrier:
Other Insurance Policy #:	Other Insurance Phone #:	Policy Holder Date of Birth:

NOTICE: PLEASE REFER TO FRAUD WARNING STATEMENT(S) INCLUDED ON THE SECOND PAGE OF THIS FORM.

Insured's Signature:	**Date:**

STUDENT HEALTH CENTER REFERRAL

Did Receive A Referral:	Health Center Closed:	This was an Emergency:	I was more than 50 miles from campus:	Other: (please explain):
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	

SHC Employee Signature:	**Date:**

GUIDELINES FOR SUBMITTING CLAIMS TO UnitedHealthcare **Student**Resources

- Clip, do not staple, all bills to the complete form and mail them to UnitedHealthcare at the address listed on your ID Card.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- **Mail claim to:** UnitedHealthcare **Student**Resources P. O. Box 809025 Dallas, TX 75380-0925 **OR**
  Fax claim to: 469-229-5625