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: / /

UnitedHealthcare