Member ID (from Health Plan ID card): F45768506

Group Number (from Health Plan ID card): G0864199

Patient Information

Name (Last, First, MI): ANUHYA MANDALAPU

Date of Birth: 04 / 05 / 1986

Home Address: 7832 LOUSIANA ST

Gender: ○ M ● F

Relationship to Subscriber / Policyholder: ● Subscriber/Policyholder ○ Spouse/Partner ○ Child ○ Other Dependent

City: BACKENRIDGE

State: HO

ZIP Code: 96987

New Address?: ○ Yes ● No

Phone #: (734) 098-2113

Subscriber/Policyholder Information

(Complete this section only if it is different than the patient information.)

Employee Name (Last, First, MI): NEERAB KUMAR

Phone #: ( ) –

Home Address: 2300 ARAPAHOE AVE

Date of Birth: 88 / / 888

City: BOULDER

State: 88

ZIP Code: 888

New Address?: ● Yes ○ No

Provider Information

Provider Name: INDIAN HEALTH CARE

Provider Tax Identification #:

Provider Address: 7832 IRIS AVE

City: BOULDER

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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