

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: / /