



**DATE:** 20-Apr-2021  
**ATTENTION:** Atención  
**FACILITY NAME:** REINTEGROS CHILE NUEVO  
**ADDRESS:** Dire prestador  
**PHYSICIAN NAME:** Nombre Médico  
**PHONE:** Tel  
**FAX:** Fax  
**EMAIL:** robertoiann@hotmail.com

### VERIFICATION OF BENEFITS

<b>FIRST NAME:</b> SALO	<b>MIDDLE I:</b> S	<b>LAST NAME:</b> EUGE
<b>DATE OF BIRTH:</b> 27-Dec-1984	<b>GENDER:</b> Female	<b>UHC GROUP NAME:</b> Universal Assistance
<b>GROUP No:</b> 76570170	<b>PLAN No:</b> 767000570170	<b>CLASS CODE:</b> 001
<b>UHC MEMBER ID:</b> 917720528401	<b>EFFECTIVE DATE:</b> 29-Jul-2019	<b>LOCATION CODE:</b> 001
		<b>CANCEL DATE:</b> 26-Nov-2021

<b>DIAGNOSIS:</b> Diag
<b>PROCEDURE:</b> Proceed
<b>SERVICE SETTING:</b> Inpatient
<b>DATE OF SERVICE :</b> 29-Nov-2022

**IF THE PATIENT IS ADMITTED TO ER – PLEASE NOTIFY AT: 1-877-303-7750**

<b>DEDUCTIBLE \$</b> 1231	<b>COINSURANCE RATE:</b> 234%
<b>PLAN MAXIMUM:</b> \$ 234	
<b>EXCLUSIONS/LIMITATIONS:</b> implantable devices	
<b>COMMENTS:</b> Coment	

The above referenced patient is enrolled in a plan that is part UnitedHealthcare's Options PPO network. The member's benefits are paid according to the contracted rate with UnitedHealthcare. The above mentioned has an Insurance policy administered by Universal Assistance in conjunction with UnitedHealthcare.

All invasive or aggressive treatment must be pre-authorized by the assigned Case Manager. All unauthorized treatment will be subjected to a review. Providing all policy requirements are met at the time services are rendered, eligible expenses will be considered in accordance with the terms and conditions of the policy and based on the reimbursement schedule per your agreement with United Healthcare. If provider is out-of-network the member's benefits are paid according to the out-of-network arbitrations program. This is not a guarantee of payment.

In order to proceed with the payment, all claims must be submitted on a HCFA/CMS or a UB form. An itemized statement must accompany all UB forms.

**Please note this plan is associated with our NEW Claims Address and Payor ID**  
**Please update your billing systems:**  
UnitedHealthcare Global  
PO Box 30526  
Salt Lake City, UT 84130-0526  
Electronic payor ID: USN01

To check claim status or verify eligibility log on to: [www.usnetworksuhc.com](http://www.usnetworksuhc.com)  
For general questions or claim inquiries call **1-877-303-7750**

**This facsimile transmission may contain protected and privileged, highly confidential medical and/or legal information. If you are not the intended recipient, please immediately notify the sender at 1-877-303-7750. Thank you for your help in maintaining appropriate confidentiality.**

**Dear Provider: This plan is associated with our NEW Claims Address & Payor ID**

**Please update your billing systems.**


UnitedHealthcare Global  
PO BOX 30526  
Salt Lake City, UT 84130-0526  
Payor ID: USN01

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**ID CARD:**

**FRONT**

**BACK**

 <b>UnitedHealthcare</b> Health Plan (80840) 911-87601-04 UnitedHealthcare Member ID: 917720528401    Group Number: 76570170 <hr/> Member: SALO EUGE Group Name: UNIVERSAL ASSISTANCE <hr/> Payor ID: USN01	For any inquiry or assistance call: <b>1-877-303-7750</b>  This card does not guarantee coverage. To verify benefits:  <b>Medical Providers:</b> Medical Claims: UnitedHealthcare Global, PO Box 30526, Salt Lake City, UT 84130-0526
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