UNIVERSITY OF UTAH HEALTH PLANS

MEDICAL CLAIM FORM

Please fill in all information legibly and completely.

PATIENT NAME		PATIENT'S BIRTHDATE	
MEMBER NAME		PATIENT RELATIONSIP TO MEMBER	
MEMBER ID#		PHONE NUMBER	
MEMBER HOME ADDRESS	CITY	STATE	ZIP
DATE OF SERVICE	IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN? WORK RELATED? YES____NO___		
IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN? YES_____NO_____ POLICY NUMBER NAME AND ADDRESS OF OTHER INSURANCE COMPANY			

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any insurance company, prepayment organization, employer hospital, or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan provider benefits or services. I hereby certify the information provided is correct and to the best of my knowledge.

_____

Signature of Patient or Parent (if patient is a minor) Date

PROCEDURE FOR FILING A CLAIM

1. Please attach all medical bills relating to the claim(s). Missing or incomplete claim information could delay processing and reimbursement.
    a. Make sure the bills identify the patient.
    b. All bills should show the date of treatment, description of service and amount of charges.
    c. Procedure Codes and Diagnosis codes must be included or claim form will be returned.
    d. All statements should have your identification number listed.
    e. Mail to: University of Utah Health Plans
        PO Box 45180
        Salt Lake City, UT 84145-0180
    f. Or fax to 801-281-6121 ATTN: Member Reimbursement
    g. Or email to uuhp@hsc.utah.edu