UnitedHealthcare Medical Claim Form

What is this form for?

Use this form to request payment for eligible care you've already received.

Things to remember

- Complete this form on your computer before printing it. You can also complete it by hand.
- Make a copy of this claim form, claim details and receipt(s) to keep for your records.
- Send the claim as soon as you can and as close to the date of service as possible.
- Be sure your member ID and the provider's or facility's details are clear and complete on the claim. This will help you receive faster payment.
- Send a detailed claim of the services from your provider, not just a receipt of your payment. Details like service codes and diagnosis codes are needed to process your claims quickly and correctly.

If you have not paid your out-of-network bill in full, mail your claim form to:

UnitedHealthcare Shared Services
P.O. Box 30783
Salt Lake City, UT 84130-0783

If you have already paid your out-of-network bill in full, mail your claim form to:

GEHA
P.O. Box 21542
Eagan, MN 55121

What happens next

After processing your claim, you'll receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future.

Member ID (from Health Plan ID card):

								G	E	H	A

Group Number (from Health Plan ID card):

7	8	-							

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: