MEDICAL CLAIM TRANSMITTAL

UnitedHealthcare
A UnitedHealth Group Company

HANFORD EMPLOYEE WELFARE TRUST
Group Number: 702633

PO Box 30555
Salt Lake City, UT 84130-0555
1-866-249-7606

A. MEMBER/EMPLOYEE INFORMATION

Member # (SSN):		Phone #: ( )	
Last Name:	First Name:	MI:	Date of Birth:
Home Address:			New Address: Yes ☐ No ☐
City:	State:		Zip Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth:

B. PATIENT INFORMATION

Last Name:	First Name:		MI:	Date of Birth:
Home Address:				
City:		State:		Zip Code:
Sex: M ☐ F ☐	Relationship To Member:	Full Time Student: Yes ☐ No ☐	School Name:	School Phone #: ( )

C. ACCIDENT INFORMATION

Work Accident? Yes ☐ No ☐	Auto Accident? Yes ☐ No ☐	Date Accident Occurred:
How did the Accident Occur:		

D. OTHER INSURANCE

Is the patient covered by another plan?: Yes ☐ No ☐ If yes, please complete the following	
Name of the person carrying other insurance:	Date of Birth:
SSN #:	Name of Other Insurance Carrier:
Policy Number:	Employer Name:

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.

Member Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below ***only if you want UnitedHealthcare to pay benefits directly to the provider*** of medical services.

Member Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not stable, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Member Number on all documents.