



HEALTH CLAIM TRANSMITTAL

UnitedHealthcare
A UnitedHealth Group Company
PO Box 740800
Atlanta, GA 30374-0800

East End Health Plan
Policy Number: 709766
Customer Service: 888-607-5214

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or SSN: Phone #: Last Name: First Name: MI: Date of Birth: Home Address: 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: Relationship to Subscriber: Full Time Student: School Name: School Phone #:

C. ACCIDENT INFORMATION

Work Accident: Auto Accident: Date Accident Occurred: How did the accident occur?

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Name of 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.

Subscriber Signature: Date:

E. ASSIGNMENT OF BENEFITS

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

Subscriber Signature: Date:

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, 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 Subscriber # or SSN on all documents.