



PO Box 30882  
Salt Lake City, UT 84130

Customer Service:  
(888) 350-5608  
M-F 7:00 a.m. – 9:00 p.m. PST

### HEALTH CLAIM FORM

Participant Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Participant Address: \_\_\_\_\_ Check If New Address

Participant Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Status:  Active  Retired  Continued (COBRA)  
Area Code Number

Spouse Name: \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship: \_\_\_\_\_

Nature of Illness or Injury: \_\_\_\_\_

**IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED**

Do You Have More Than One Employer? Yes  No

Is Your Spouse Employed? Yes  No  Is Patient Employed? Yes  No

If you answered "yes" to any of the above questions, please provide the following information

Employed Person: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: **County of Orange**

Employer Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
Area Code Number

Insurance Company & Policy Number: **UnitedHealthcare #710257** \_\_\_\_\_

**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.**

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**HINTS FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE**

- If you want UnitedHealthcare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).
- Attach your bills to this completed form and mail them to UnitedHealthcare at the address shown above. COBRA continues mail to the UnitedHealthcare claim office you used as an active employee (or as a dependent of an active employee).
- Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.
- Send additional bills periodically or when they total \$50.00 or more.

**For UnitedHealthcare USE ONLY**

DATE BENEFITS BECAME EFFECTIVE			DATE BENEFITS TERMINATED			SUFFIX	ACCOUNT							
MO.	DAY	YEAR	MO.	DAY	YEAR			MO.	DAY	YEAR				
Emp.			Dep.			Emp.			Dep.					
SIGNATURE OF UNITEDHEALTHCARE EMPLOYEE CERTIFYING BENEFITS:											DATE	MO.	DAY	YEAR