BARCODE SPACE HERE

HEALTH CLAIM TRANSMITTAL

UnitedHealthcare
A UnitedHealth Group Company

Employer Name: Escambia County School District
Group (policy) ***Number: 202948***

Mail Claims To:
Claims Mail Drop
P.O. Box 740800
Atlanta, GA 30374-0800

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber# or 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 Subscriber:	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 insurance plan? Yes ❑ No ❑ If yes, please complete the following:		
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 UnitedHea/thcare 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 listed on your ID card.
- 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.