

HEALTH CLAIM TRANSMITTAL

**NEW YORK UNIVERSITY
POLICY # 175396**

**Point of Service:
1-866-633-2474**

**PO Box 740800
ATLANTA, GA 30374-0800**

A. MEMBER/EMPLOYEE INFORMATION

Member # (SSN):		Phone #:	
Last Name:	First Name:	MI:	Date of Birth:
Home Address:			New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>
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:
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Member:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: ()

C. ACCIDENT INFORMATION

Work Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the accident occur?:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 BE SUBJECT TO CIVIL PENALTIES.	
Member Signature: _____	Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below <u>only if you want United HealthCare to pay benefits directly to the provider of medical services.</u>	
Member Signature: _____	Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

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