Medical Claim Form

What is this form for?

This form is for out-of-network claims ONLY, and should be used only for the Enhanced, Standard and HSA options in the Fordham Medical Plan, to ask for payment for eligible health care you have received.

Important instructions:

- Submit the claim as soon as you can. We need to receive your claim within 90 days of the date you received the services.
- Clearly write your membership number and the provider or facility details on the claim.
- Include a detailed description of the services from your provider, not just a receipt of your payment. We need details like service codes and diagnoses, as well as place of service type (i.e., "office," "inpatient," etc.) in order to process your claim quickly and correctly.
- Make a copy of the claim form, claim details and receipt(s) to keep for your records.
- Mail your form with the claim details and receipt(s) to the address on your health plan ID card or in your Welcome Packet.

How to get the maximum benefit:

Use a UnitedHealthcare provider to receive the maximum benefit. Durable medical equipment and ongoing services such as physical therapy are especially cost effective with a UnitedHealthcare provider.

What happens next:

After we process your claim, we will send you an Explanation of Benefits (EOB). The EOB will explain the charges applied to your plan deductible and any charges you owe your health care provider. Please keep your EOB on file for future reference. You may also review your EOB information online at **myuhc.com.**

For mental/behavioral health care only: Submit online for faster payment

If you received mental health or substance use services, you can skip this form and submit your claim online for faster processing and easier tracking.

Here's how:

- Go to myuhc.com. Sign in to your account.
- On the right of the screen, select: Mental Health & Substance Use. This will take you to the Live & Work Well page.
- Under Quick Links, select Claims and Coverage.
- Under Submit a Claim, follow the directions on how to submit online.

Online submission is only for mental health claims. It is not available for medical claims.

Member ID (from Health Plan ID card): ☐☐☐☐☐☐☐☐☐

Group Number: 9 0 2 7 6 5

Patient Information.

Name (Last, First, MI): ____________________

Date of Birth: __ __ / __ __ / __ __ __ __

Home Address: ____________________

Gender: ○ M ○ F

City: ____________________ State: ____ ZIP Code: __________

New Address?: ○ Yes ○ No

Phone #: (___) ___ – ____

Relationship to Subscriber / Policyholder:
○ Subscriber/Policyholder
○ Spouse/Partner
○ Child
○ Other Dependent

Subscriber/Policyholder Information.

(Complete this section only if it is different than the patient information.)

Employee Name (Last, First, MI): ____________________

Phone #: (___) ___ – ____

Home Address: ____________________

Date of Birth: __ __ / __ __ / __ __ __ __

City: ____________________ State: ____ ZIP Code: __________

New Address?: ○ Yes ○ No

Provider Information.

Provider Name: ____________________

Provider Tax Identification #: ____________________

NPI Number: ____________________

License Number: ____________________

Provider Address: ____________________

City: ____________________ State: ____ ZIP Code: __________

Phone #: (___) ___ – ____

Accident Information.

Date of Accident: __ __ / __ __ / __ __ __ __

Type of Accident: ○ Work ○ Auto ○ Other

How did the accident happen?

____

____

Other Insurance.

Is the patient covered by another insurance plan? ○ Yes ○ No (If yes, please complete the following information.)

Name of person carrying other insurance (Last, First, MI): ____________________

Date of Birth: __ __ / __ __ / __ __ __ __

Name of Other Insurance Carrier: ____________________

Policy Number: ____________________

Employer Name: ____________________

Services. To be completed by Provider.

State:

Diagnosis Codes: ______ ______ ______ ______ ______ ______ ______

Place of Service	CPT/HCPC/Rev Codes	Modifier	Units	Date of service	Charge for each service

Total Billed Charges: ____________

Assignment of Benefits.

To be completed by Provider.

Assignment of Benefits

☐ Please check this box if you want UnitedHealthcare to pay benefits directly to the doctor/provider.

By signing below, I am stating that the information above is correct. 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.

Signature: ____________________ Date: __ __ / __ __ / __ __ __ __

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