HEALTH CLAIM TRANSMITTAL

New York University
Policy # 175396

Managed Indemnity:
1-800-214-1736

UNITEDhealthcare®
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 ☐ 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 Member:	Full Time Student: Yes☐ No☐	School Name:	School Phone #: ( )

C. ACCIDENT INFORMATION

Work Accident? Yes☐ No☐	Auto Accident? Yes☐ No☐	Date Accident Occured: / /
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.

Member Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

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

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 address above.
- 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.