

HEALTH CLAIM TRANSMITTAL

UnitedHealthcare[®]

A UnitedHealth Group Company

PO Box 740800 Atlanta, GA 30374-0800

Suffolk Schools Employees Health Plan

Policy Number: 710635

Customer Service Toll-Free Number: 866-844-4864

Policy Number: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GL AND MAY BE SUBJECT TO C Subscriber Signature: E. ASSIGNMENT OF BENEFITS	Phone #:	Phone #:	
Name: Home Address: City: Spouse Last Name: 3. PATIENT INFORMATION Last Name: Home Address: City: Sex: M F Relationship to Subscriber: C. ACCIDENT INFORMATION Work Accident: Yes No Accident: Yes No How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIR FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GL AND MAY BE SUBJECT TO C Subscriber Signature:	()	
Address: City: Spouse Last Name: Name: S. PATIENT INFORMATION Last Name: Home Address: City: Sex: M F Relationship to Subscriber: C. ACCIDENT INFORMATION Work Accident: Yes No Accident: Yes No How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUAND MAY BE SUBJECT TO C. Subscriber Signature: E. ASSIGNMENT OF BENEFITS	MI:	Date of Birth:	
Spouse Last Name: 3. PATIENT INFORMATION Last Name: Home Address: City: Sex: M F Relationship to Subscriber: C. ACCIDENT INFORMATION Work Accident: Yes No Auto Accident: Yes No How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN:		New Address: Yes □ No □	
Last Name: B. PATIENT INFORMATION Last Name: Home Address: City: Sex: M		Zip Code:	
Last Name: First Name: Home Address: Sex: M F Relationship to Subscriber: Full Time Student Yes No C. ACCIDENT INFORMATION Auto Accident: Yes No Accident: Yes No Accident: Yes No Accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN:	MI:	Spouse Date of Birth:	
Name: Name: Home Address: City: State: Sex: M F Relationship to Subscriber: Yes No C. ACCIDENT INFORMATION Auto Accident: Yes No Accident Yes No Accident			
Address: City: Sex: M F Relationship to Subscriber: C. ACCIDENT INFORMATION Work Accident: Yes No Accident: Yes No How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO C. Subscriber Signature: E. ASSIGNMENT OF BENEFITS	MI:	Date of Birth:	
Sex: M F Relationship to Subscriber:	= 1		
to Subscriber: C. ACCIDENT INFORMATION Work Accident: Yes No Accident: Y		Zip Code:	
Work Accident: Yes No Decident No Accident: Yes No Decident No Deci	School Name:	School Phone #:	
Accident: Yes No Accident: Yes No How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN: Name of person How Many North Insurance: Policy Number: Emp Name Any Person WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE GLAND MAY BE SUBJECT TO COMPLETE OR MISLEADING INFORMATION MAY BE SUBJECT TO COM			
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Is the patient covered by another insurance plan? Yes No If yes, please complete Name of person carrying other insurance: SSN: Policy Number: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO COSUBSCRIBER SIGNATURE: Subscriber Signature: E. ASSIGNMENT OF BENEFITS			
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Number: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO CONSUMER SIGNATURE: E. ASSIGNMENT OF BENEFITS	Name of Other Insurance Carrier:		
FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GLAND MAY BE SUBJECT TO C Subscriber Signature: E. ASSIGNMENT OF BENEFITS	Employer Name:		
	ILTY OF A CRIMINAL ACT VIL PENALTIES.		
Diagon sign balow only if you want I hite all lealth ages to to fit five -			
Please sign below only if you want UnitedHealthcare to pay benefits direct	ly to the provider of medica	I services.	
Subscriber Signature:			

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- 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.