UCI

HEALTH CLAIM TRANSMITTAL

Sandia National Laboratories
Policy 708576

UnitedHealthcare
P.O. Box 740809
Atlanta, GA 30374
1-877-835-9855

SF 4500-UHC (3-2006) Supersedes (1-2006) Issue	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:

A. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth:
Home Address:			
City:		State:	Zip Code:
Sex: M ☐ F ☐	Relationship To member:		

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 plan? Yes ☐ No ☐	If yes, please complete the following
Name of the 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 UnitedHealthcare to pay benefits directly to the provider* of medical services.

Member 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 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 you Member Number on all documents.