

HEALTH CLAIM TRANSMITTAL

INSURED INFORMATION					
Last Name:		First Name:		Middle Initial:	
Student Insurance ID# or Social Security#:		Home phone #:		Birth date:	
		()		/ /	
Street address:		P.O. box:	City:		State:
					ZIP Code:
PATIENT INFORMATION (IF DIFFERENT FROM ABOVE)					
Last Name:		First Name:		Middle Initial:	
Street address:		City:		State:	
P.O. box:		ZIP Code:		Birth date:	
Patient's relationship to student:					
<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other
ACCIDENT INFORMATION					
<input type="checkbox"/> Work Accident:	<input type="checkbox"/> Auto Accident:	<input type="checkbox"/> Intercollegiate Sport Accident:		<input type="checkbox"/> Intramural Sport Accident:	<input type="checkbox"/> Interscholastic Sport Accident:
Date Occurred:		Type of Sport (ex: Football, etc.):			
Details of Accident:					
INJURY / SICKNESS INFORMATION					
Have you suffered the same or a similar condition in the past?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, and if you were treated for it, please give the name and address of the physician who treated you.					
Physician's Name:		Physician's Address:			Date Treated:
I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR OTHER MEDICAL PROVIDER TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, OR BENEFITS PAYABLE FOR THIS CLAIM TO UNITEDHEALTHCARE INSURANCE COMPANY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.					
Insured's Signature:				Date:	
OTHER INSURANCE INFORMATION					
(If the patient is covered by another insurance plan, please complete the following.)					
Name of person carrying other insurance:		Subscriber # or Social Security#:		Name of other insurance carrier:	
Other Insurance Policy #:		Other Insurance Phone #:		Policy Holder Date of Birth:	
NOTICE: PLEASE REFER TO FRAUD WARNING STATEMENT(S) INCLUDED ON THE SECOND PAGE OF THIS FORM.					
Insured's Signature:				Date:	
STUDENT HEALTH CENTER REFERRAL					
Did Receive A Referral:	Health Center Closed:	This was an Emergency:	I was more than 50 miles from campus:		Other: (please explain):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
SHC Employee Signature:				Date:	

GUIDELINES FOR SUBMITTING CLAIMS TO UnitedHealthcare **StudentResources**

- Clip, do not staple, all bills to the complete form and mail them to UnitedHealthcare at the address listed on your ID Card.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- **Mail claim to:** UnitedHealthcare **StudentResources** P. O. Box 809025 Dallas, TX 75380-0925 **OR**
Fax claim to: 469-229-5625