UnitedHealthcare®

CLAIM INFORMATION FORM

For Use Only With Policies Underwritten by Student Resources (SPC) Ltd.

INSURED INFORMATION

Last Name:	First Name:	Middle Initial:

SR ID#(refer to your ID card):	Home phone #: ( )	Date of Birth (mm/dd/yy): / /	Email address:

U.S. Mailing address:	P.O. Box:	City:	State:	ZIP Code:

PATIENT INFORMATION (IF DIFFERENT FROM INSURED)

Last Name:	First Name:	Middle Initial:

U.S. Mailing address:	P.O. Box:	City:

State:	ZIP Code:	Home phone #: ( )	Date of Birth(mm/dd/yy):

Patient's relationship to student: ❑ Self ❑ Spouse ❑ Child ❑ Other (please explain)

ACCIDENT INFORMATION

Type of Accident: ❑ Auto ❑ IC Sport ❑ Intramural Sport ❑ Interscholastic Sport ❑ Work ❑ Other

Date Occurred:	Type of Sport (Football, track, etc.):

Details of Accident:

INJURY / SICKNESS INFORMATION

Have you suffered the same or a similar condition in the past? ❑ Yes ❑ No If Yes, and if you were treated for it, please provide information:

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 United Healthcare Insurance Company. A photocopy of this authorization shall be as valid as the original.

Insured's Signature:	**Date:**

OTHER INSURANCE INFORMATION

Is the patient covered by another insurance plan? ❑ Yes ❑ No If you checked "Yes", please complete the section below.

Name of person carrying other insurance:	Subscriber #:	Name of other insurance carrier:

Other Insurance Policy #:	Other Insurance Phone #:	Policyholder Date of Birth(mm/dd/yy):

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and/or civil penalties.

Insured's Signature:	**Date:**

STUDENT HEALTH CENTER REFERRAL

A Referral was received:	Health Center Closed:	This was an Emergency:	I was more than 50 miles from campus:	Other (please explain):
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	

Guidelines for Submitting Claims to UnitedHealthcare **Student**Resources

- Bills must include diagnosis code, procedure code, service date and cost. Clip, do not staple, all bills to this completed form.
- For prescription claims, provide receipt or computer printout from the Pharmacy which includes Medicine name, date dispensed and price with your name, address and SR ID#. A claim form is not required.
- **Mail claim to:** UnitedHealthcare **Student**Resources , P. O. Box 809025, Dallas, TX 75380-9025 (This is listed on your ID card)
- **Fax claim to:** 469-229-5625
- **Email :** A scanned copy of the completed form to SI.DRG@uhcsr.com