

# MEDICAL CLAIM FORM



**Group Name: Enterprise Holdings**

**Group #: 703995**

PO Box 30555  
SALT LAKE CITY, UT 84130-0555  
CALL TOLL FREE: 1-800-520-0746

## 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 Date Accident Occurred? Yes No
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:
<b>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.</b>	
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 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.