

HEALTH CLAIM TRANSMITTAL

NYU School of Medicine Student Health Insurance
 Policy Number: 702491
 Choice Plus: 866-633-2446

UNITEDhealthcare®
 PO Box 740800
 Atlanta, GA 30374-0800

A. MEMBER/EMPLOYEE INFORMATION

Member # (SSN):		Phone #: ()	
Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:		New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Member:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: ()

C. ACCIDENT INFORMATION

Work Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the accident occur:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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:

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 United HealthCare 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 NYU School of Medicine Registrar Office of all address changes.
- Please include your Member Number on all documents.