HEALTH CLAIM TRANSMITTAL

UnitedHealthcare®
A UnitedHealth Group Company

Customer Name: The McGraw-Hill Companies
Policy #: 242447

P.O. Box 740800
Atlanta, GA 30374-0800
1-866-328-6575

A. MEMBER/EMPLOYEE INFORMATION

Member # (SSN): --- ---		Phone #: ( )	
Member (EIN)			
Last Name:	First Name:	MI:	Date of Birth: / /
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth: / /
Please note that all claim reimbursements will be sent to the members address on file.			

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 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 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 your employer of all address changes.
- Please include you Member Number on all documents.