

HEALTH CLAIM TRANSMITTAL

AFL-CIO Health & Welfare Plan
Housing Investment Trust
713782



A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or 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 Subscriber:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: School Phone #: ()

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.

Subscriber Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below *only if you want UnitedHealthcare to pay benefits directly to the provider* of medical services.

Subscriber Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your Subscriber # or SSN on all documents.