Statement of Claim for Medical Expense Benefits

UNITEDhealthcare℠

▲ **Do Not Write Above This Line**

Employee's Statement

Answer all questions below omitted information will cause delays.

Name (print) First Middle Last	Social Security Number: (Employee)	Date of Birth	☐ Male ☐ Female
Present Address: Street City State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Phone No. ( )	

Dependent Information – Complete this section only if expenses were incurred by an eligible dependent or dependents.

Name (print) First Middle Last	(Dependent) Social Security Number		☐ Student ☐ Disabled If Student, Name of School & City
Date of Birth	Relationship	☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married

Family Employment – Complete this section only if other members, including dependent minors, are employed.

Name of Family Member (print) First Middle Last	Relationship	Date of Birth	Employer's/School's Phone No ( )
Employer's/School's Name (print)	Employer's/School's Address - Street City State Zip Code		

Accident Information – Complete this section only if claim is result of accidental injury or occupational sickness.

Date of Accident	Time of Accident : ☐ A.M. ☐ P.M.	Where Did the Accident Occur? (City/State)	Did the Accident/Sickness Happen at Work? ☐ Yes ☐ No
Describe Accident or Occupational Sickness: Type of Accident: ☐ Auto ☐ Other			

Medicare Information – Complete this section only if Patient is eligible for Medicare.

Please Attach a Copy of the "Explanation of Benefits" Statement From Your Medicare Insurance Carrier.	Medicare	Part A	Effective Date	Part B	Effective Date

Other Coverage Information – This section must always be completed.

Are any benefits or services provided under another group insurance plan or any prepayment plan, or pursuant to any law (Federal, State, or Local) on account of the treatment reported on this claim?

☐ Yes ☐ No

If "Yes", answer (A) or (B), which ever applies, and (C).

A. Other Insurance Coverage is: ☐ Group ☐ Individual ☐ Other (specify) ▶

B. Name or Type of Law is (e.g., Medicaid, Champus, No-Fault)

C. Give Name and Address of Other Company or Organization Providing Benefits or Services.

Name

Address

City State Zip Code

Please Indicate Plan Identification No. or Blue Cross/Blue Shield Group No.(s). ▶

Itemized Bills – Attach itemized bills for expenses not reported on this form. All such miscellaneous bills must show:

a. Employee's Name b. Patient's name (if not employee) c. Name and Address of Provider of Services d. Diagnosis
e. Complete Description of Services Rendered f. Initials of Attending or Prescribing Physician g. Dates (month, day, year) of Service.

Medical Authorization

Insured employee or surviving spouse must sign for all claims. Dependent patient must also sign if not a minor.

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signed (Employee or surviving spouse) ▶ Date

Signed (Dependent patient who is not a minor) Date

Payment of Benefits – Check all appropriate boxes before signing.

Except where my plan provides for authomatic payment of benefits to the provider(s) of services, I authorize payment of benefits, as determined by the Insurance Company, directly to:

Hospital ☐ Yes ☐ No Surgeon/Physician ☐ Yes ☐ No

I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by the Insurance Company in the event that the charges made are not reasonable and customary.

Signed (Employee or Surviving Spouse) ▶ Date

Authorizations will be honored only if a valid Tax Identification or Social Security Number for the provider is shown on the claim form.

Mail Completed Form To ▶ United HealthCare Insurance Company P.O. Box 740800 Atlanta, GA 30374-0800

Employer **CITGO Petroleum Corporation**

Group No. **229556**

IMPORTANT – To all Providers of Services:
In lieu of completing your part of this form, you may use your own letterhead if it contains the same information requested hereon.

It is a crime to fill out this form with facts you know are false or to leave out facts you know are important

Hospital Statement

Name of Patient	Age	Date Admitted	Time Admitted ☐ A.M. ☐ P.M.	Date Discharged	Time Discharged ☐ A.M. ☐ P.M.

If Patient had other than semi-private room, indicate most common semi-private rate $	Other Insurance indicated by hospital records? ☐ Yes ▶ ☐ No	Name of Company	Amount Paid $

ICD-9 Code	Diagnosis From Records (If injury, give date and place of accident)

Operations or Obstetrical Procedures Performed (Nature and date)	Taken from Records on

Hospital	Provider I.D. No.	Telephone No. ( ) Area Code

Address	Signed Date

Physician's/Surgeon's Statement

1. Patient's Name (First name, middle initial, last name)	2. Patient's Date of Birth

3. Date of Illness (First Symptom) or injury (Accident) or Pregnancy (LMP)	4. Date the Patient First Consulted You for this Condition	5. Has Patient ever Had Same or Similar Symptoms? ☐ Yes ☐ No

6. Name & Address of Referring Physician

7. For Services Related to Hospitalization, Give Hospitalization Dates	Date Admitted:	Date Discharged:	8. Was Laboratory Work Performed Outside Your Office? ☐ Yes ☐ No ▶ Charges $

9. Name & Address of Facility Where Services Were Rendered (if other than home or office)

10. If Anesthesia was Administered, Give Date	11. Duration of Anesthesia Hours: Min.:	12. Do You Consider the Injury or Sickness Work Related? ☐ Yes ☐ No

13. If Patient Has Additional Coverage, Please Identify

14. Diagnosis or Nature of Illness or Injury — Relate Diagnosis to Procedure in Column C by Reference to Numbers 1, 2, 3, Etc.

1.
2.
3.
4.

15. A Place of Service*	B. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given: CPT-4 Procedure Code Identity	(Explain Unusual Services or Circumstances)	C IC Diagnosis Code	D Charges	E Date of Service	16. Amount Paid
				$		
				$		$
				$		
				$		17. Balance Due
				$		
				$		$
18. Your Patient's Account No.				19. Total Charge $		
20. Physician's/Surgeon's Name		Address			21. Telephone No. ( ) Area Code	
22. Signed ▶		Date		23. Social Security No. ▶	/ /	
*Place of Service Codes **(H)** – Hospital (inpatient) **(O)** – Office **(M)** – Home **(X)** – Hospital (outpatient) **(E)** – Elseware **(D)** – Daycare **(K)** – Nightcare **(C)** – Convalescent Facility **(A)** – Ambulatory Surgicenter				24. Provider I.D. No ▶	/	
				Authorizations will not be honored unless a valid Tax Identification or Social Security Number is shown above.		