

University Health Care Plus MEDICAL CLAIM FORM

PATIENT NAME		PATIENT'S BIRTHDATE	
EMPLOYEE NAME		PATIENT RELATIONSHIP TO EMPLOYEE	
EMPLOYEE ID #		PHONE NUMBER	
EMPLOYEE HOME ADDRESS		CITY	STATE
		ZIP	
DATE OF SERVICE	IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN? WORK RELATED? YES _____ NO _____		
IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN? YES _____ NO _____			
POLICY NUMBER			
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and to the best of my knowledge.

Signature of Patient or Parent (if patient is a minor)

Date

PROCEDURE FOR FILING A CLAIM

1. Attach all medical bills relating to the claim(s).
 - A. Make sure the bills identify the patient.
 - B. All bills should show the date of treatment, description of service, and amount of charges.
 - C. All statements should have your identification number listed.
 - D. Mail to: University Health Care Plus Claims
PO Box 45180
SLC, UT 84145

2. For additional information please call 587-6480 option 1 or toll free 1-888-271-5870 option 1
Monday - Friday 8:00 am to 5:00 pm.