UnitedHealthcare®

Reimbursement Form

You can use this form to ask us to pay you back for covered medical care or supplies. (Note: Check your Evidence of Coverage to determine what the plan will pay for.) Please type or print. If you have costs for more than one member, please fill out a separate form for each member. Please complete a separate form for each provider.

Information about you

First name	Last name	
Address		
City	State	ZIP code
☐ Male ☐ Female	Member ID number	
Phone number ___ – ___ – ____	Member Group number	

Are you completing this form for the member? If yes, please give your name and phone number below:

What is your relationship to the member?

☐ Spouse or partner ☐ Relative ☐ Attorney ☐ Estate Representative ☐ Other _____

Information about other insurance

Do you have other insurance besides Medicare? For example: Medicaid, employer or VA insurance. Medicare has rules about when it pays if you have other coverage. Please list below.

Name of insurance	Policy number

Was your illness or injury due to an accident covered by workers' compensation (WC), but WC doesn't cover it? ☐ Yes ☐ No

If yes, please send us a copy of the paperwork saying that WC doesn't cover your illness or injury. For example, a letter from WC or a lawyer. Or, an Explanation of Benefits from WC.

Were you injured or became ill due to a car accident, but your auto policy doesn't cover it?
☐ Yes ☐ No

If yes, please send us a copy of the paperwork from the auto insurance company saying that it doesn't cover your illness or injury. For example, a letter from the insurance company or a lawyer.

Information about your injury or illness

Did you need to go to urgent care or the emergency department? ☐ Yes ☐ No

Did you need to get dialysis outside of the plan's service area? ☐ Yes ☐ No

☐ Doctor's office ☐ Urgent care ☐ Emergency room ☐ Assisted living facility or nursing home

Where did you get the service(s) or item(s)?

☐ Pharmacy ☐ Home ☐ Other _____

Provider name

Address

City	State	ZIP code

Details about your medical care of supplies

We need information about the items or medical care you paid for. You should be able to get the information from your doctor's bill or by calling your doctor's office.

Here's an example of the type of information we need:

	Date of service	Diagnosis or illness	Treatment, CPT code, or name of item	Number of items or visits	Billed amount	You paid
Example	*1/15/20XX*	*250.00 or diabetes*	*99214 or office visit*	*1*	*$123.00*	*$123.00*

Please fill in your expenses below. If you need more room, please use a separate piece of paper.

Date of service	**Diagnosis or illness**	**Treatment, CPT code, or name of item**	**Number of items of visits**	**Billed amount**	**You paid**

☐ I am adding a separate sheet for more items.

☐ For cataract frames or lenses: My cataract surgery date was: _____

Please tell us how the items listed above relate to your illness or injury:

Sign here:	Date:

When I sign above, I am stating that the information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I could face fines and prison under federal law.

If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Before you mail this form

Include proof of payment for the medical care or item. It should include the date you got the care or item, the number of items or visits, and the cost for each. It should also list how you paid (check, credit card, etc.).

If you have other insurance, please include a copy of that insurance plan's explanation of benefits.

Please include copies of any workers' compensation or auto insurance paperwork we asked for above.

Are you completing this for a member? If yes, please include a copy of the paperwork showing you have the legal right to do so. Examples of the legal paperwork are Power of Attorney and Appointment of Representative form.

Check that you signed above.

Please keep copies of everything you send us.

Where to mail this form

Please send us your paperwork no later than 365 days from the date of service.

Please mail the form and your other paperwork to the address on the back of your member ID card. We'll send you a check or a follow-up letter in 60 days.

Questions?

Call the toll-free Customer Service number on the back of your member ID card.