UNIVERSITY of COLORADO HEALTH
UCHEALTH PLAN ADMINISTRATORS

MEDICAL CLAIM FORM

This Form to be Completed by Employee

Employee Name	Social Security Number	Name of Employer	Group
Home Address	Employee Birth Date	Is Patient Full Time Student? Yes ☐ No ☐	Name and Address of School
City State Zip Code	Is Patient Covered By Medicare? Yes ☐ No ☐	Phone Number: Home _____ Work _____	
Patient (If other than employee) Name	Male ☐ Female ☐	Patient Relationship to Employee	Patient Birth Date / Is Patient Married? Yes ☐ No ☐

Is Patient Employed? Yes ☐ No ☐ If Yes, Name and Address of Employer: _____

Is Spouse Employed? Yes ☐ No ☐ If Yes, Name and Address of Employer: _____

Date Accident or Illness Began	If Injured, How and Where Did Accident Occur?	Was Motor Vehicle Involved? Yes ☐ No ☐ Did Accident Occur at Work? Yes ☐ No ☐
Nature of Illness, Injury, Diagnosis, or Medical Call		Physician's Name

Are you, the patient or spouse, covered under any other group plan, health maintenance organization, government plan, or insurance policy which will also pay for any of the Expenses of this claim? Yes ☐ No ☐. If Yes, give name, address, and policy number of plan providing benefits.

Name and Address _____ Policy # _____

A. Authorization to Release Information:

I certify that this information is complete and accurate and authorize release of medical information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

X _____
Patient or Parent (if minor) Date

B. Please pay benefits under this claim directly to:

☐ Hospital ☐ Doctor ☐ Employee

I hereby authorize payment of benefits directly to any provider(s) of service otherwise payable to me but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

Instructions

Before Sending the Claim Form:

1. Does your provider's bill indicate what services were rendered and for whom?
2. Have you answered all the questions applicable to your claim?
3. **Questions?** Contact UCHealth Plan Administrators at 970-224-4600

How to file a claim

1. Complete, date, and sign the Employee's Statement on the claim form. If all questions are not answered, a delay may occur in the consideration of the claim.
2. Attach the claim form along with all bills for which you are filing a claim.
3. Place all documents in an envelope and mail to:

UCHealth Plan Administrators
Attn: Claims Department
1024 S. Lemay Ave.
Fort Collins, CO 80524
970-224-4600

IMPORTANT: Each bill must show; (a) the name of the patient; (b) the date and charge for each service rendered; (c) the diagnosis for each item of expense; and (d) the type of service.

If benefits are being claimed for drugs, the drug bill should show the prescription numbers, name of patient, date, and charge for each prescription.

Do not present cancelled checks or cash receipts. They do not contain the information necessary to process a claim.