uchealth

CLAIM FORM

MEDICAL ☐ **DENTAL** ☐ **VISION** ☐

PLEASE COMPLETE FOR ALL MEMBER SUBMITTED CLAIMS. ATTACH RECEIPTS AND ITEMIZED BILLS* TO THIS FORM.

Employee Information: Complete in all cases

Last Name	First Name	M.I.	Enrollee Number	Group Number

Street Address	City	State	Zip Code

Employer	Date of Birth (MM/DD/YY)	Gender	Marital Status
	/ /	Male ☐ Female ☐	

Dependent Information: Complete if dependent is the patient.

Name	Date of Birth (MM/DD/YY)	Relationship	Gender
	/ /	Child ☐ Other ☐ Spouse ☐	Male ☐ Female ☐

Is patient covered by another medical plan: No ☐ Yes ☐ (If yes, attach a copy of the identification card)

Employee Name	Name of Plan	Date of Birth (MM/DD/YY)	Identification Number	Relationship

I certify that all information above is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim.

_____ _____

Employee Signature and date | Spouse Signature and date, if spouse is patient

AUTHORIZATION FOR DIRECT PAYMENT:

Sign **ONLY** if you want payment to go to the provider of service instead of coming directly to you.

_____

Employee Signature and date (REQUIRED for all claims): _____

Please submit claim and all documentation to:

UCHealth Plan Administrators
PO Box 4718
Englewood, CO 80155
Fax: 720-553-1271

* Itemized bills must contain the following information: patient's name, date(s) of treatment, diagnosis, procedure code(s), location of service, fee for each service, provider name, provider address, provider tax identification number, provider NPI number.