HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. INSURED'S ST. NUMBER: (For Program In Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. INSURED'S ADDRESS (No., Street)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S BIRTH DATE: MM DD YY

6. PATIENT RELATIONSHIP TO INSURED:
   Self ■ Spouse ■ Child ■ Other ■

7. INSURED'S ADDRESS (No., Street)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S ADDRESS (No., Street)

10. INSURED'S POLICY GROUP OR FECA NUMBER

11. INSURED'S POLICY OR GROUP NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?
   YES ☐ NO ☐

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP): MM DD YY

15. OTHER DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:
   FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?
   YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E) ICD Ind.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
   FROM MM DD YY TO MM DD YY

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
   YES ☐ NO ☐

28. TOTAL CHARGE

29. AMOUNT PAID

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED

DATE

Please print or type

APPROVED OMB-0938-1197 FORM 1500 (02-12)

NUCC Instruction Manual available at: www.nucc.org
The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department:
“Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

PLEASE MAIL CLAIMS TO: UnitedHealthcare
P.O. Box 1600
Kingston, New York 12402-1600
1-877-7NYSHIP (1-877-769-7447)
OR FAX TO (845) 336-7716