UnitedHealthcare®

If you are completing this form online, please print the form, sign, and follow one of the submission methods below. Press the tab button to move from one box to the next the text font will automatically decrease in size to fit the allotted space if the data entered is larger than the box provided. If additional space is needed, you can use a separate sheet of paper and attach it to this form.

CLAIM INFORMATION FORM

For Use Only With Policies Underwritten by **Student**Resources (SPC) LTD.

INSURED INFORMATION

Policy Year:	Policy Number:	School Name:

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	☐ Male ☐ Female	SR ID#(refer to your ID card):

Home phone #:	Date of Birth(mm/dd/yyyy):	Email address:

School or Current mailing address:	P.O. Box:	City:	State:	ZIP Code:

INJURY/SICKNESS INFORMATION

Type of Accident (if applicable): ☐ Auto ☐ Intramural Sport ☐ Interscholastic Sport ☐ Club ☐ Work ☐ Other:

Date Injury/Sickness occurred(mm/dd/yyyy):	Type of Sport (Football, Baseball, etc. if applicable):

If the injury was due to an accident, did it occur:

a) While claimant was supervised? ☐ Yes ☐ No

b) During sponsored activity? ☐ Yes ☐ No

c) During programmed hours? ☐ Yes ☐ No

d) On activity premises? ☐ Yes ☐ No

e) While traveling to or from a regularly scheduled activity in a supervised group? ☐ Yes ☐ No

Describe how accident occurred (**give all possible details**). Must be a bodily injury due to an accident.:

Body Part (s) Injured?:

Has claimant suffered the same or a similar condition in the past? ☐ Yes ☐ No If Yes, and if you were treated for it, please provide information:

Physician's Name:	Physician's Address:	Date Treated (mm/dd/yyyy):

I hereby authorize any physician, hospital, or other medical provider to release any information regarding the medical history, treatment, or benefits payable for this claim to United Healthcare Insurance Company. A photocopy of this authorization shall be as valid as the original.

Insured, Parent or Guardian's Signature:	Date(mm/dd/yyyy):

OTHER INSURANCE INFORMATION

Is the patient covered by another insurance plan? ☐ Yes ☐ No If you checked "Yes", please complete the section below.

Name of Policyholder or person carrying other insurance:	Subscriber #:	Name of other Insurance Carrier:

Other Insurance Policy #:	Other Insurance Phone #:	Policyholder Date of Birth(mm/dd/yyyy):

PAYMENT INFORMATION

Make checks payable to: ☐ Student ☐ Provider	Mailing Address:	Email Address:

NOTICE: PLEASE REFER TO FRAUD WARNING STATEMENT(S) INCLUDED ON THE SECOND PAGE OF THIS FORM.

Insured, Parent or Guardian's Signature:	Date(mm/dd/yyyy):

Guidelines for Submitting Claims to UnitedHealthcare StudentResources

- Bills must include diagnosis code, procedure code, service date and cost. Clip, do not staple, all bills to this completed form.
- For prescription claims, provide receipt or computer printout from the Pharmacy which includes Medicine name, date dispensed and price with your name, address and SR ID#. **A claim form is not required.**
- **Mail:** UnitedHealthcare **Student**Resources , P. O. Box 809025, Dallas, TX 75380-9025 (This is listed on your ID card)
- **Email :** A scanned copy of the completed form to SI.DRG@uhcsr.com