UnitedHealthcare®

CLAIM INFORMATION FORM

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

PRIVATE SECONDARY SCHOOLS

Policy Year:	Policy Number:	School Name:

INSURED STUDENT INFORMATION

Last Name:	First Name:	Middle Initial:	❑ Male ❑ Female

SR ID#(refer to your ID card):	Home phone #: ( )	Date of Birth (mm/dd/yy): / /	Email address:

School or Current U.S. Mailing address:	P.O. Box:	City:	State:	ZIP Code:

INJURY/SICKNESS INFORMATION

Type of Accident (if applicable): ❑ Auto ❑ Intramural Sport ❑ Interscholastic Sport ❑ Work ❑ Other _____

Date Injury/Sickness occurred:

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.

_____

_____

_____

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:

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:**

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/yy): / /

PAYMENT INFORMATION

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

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and/or civil penalties.

Insured, Parent or Guardian's Signature:	**Date:**

Guidelines for Submitting Claims to UnitedHealthcare **Student**Resources

- 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

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