UnitedHealthcare Global Expatriate Insurance Claim Form

Return this form with a copy of the bill(s) or receipt(s) via mail, fax, or email.

Claim Type(s): ○ Medical ○ Dental ○ Vision ○ Pharmacy/Rx

Website:	**Mobile:**	**Address:**	**Fax:**	**Direct Dial Fax:**
Submit Claims online at www.myuhc.com	Submit claims via the UHC Global app on your smartphone	UnitedHealthcare Global PO Box 740111 Atlanta, GA 30374-0111	+1.877.370.4150	+1.813.870.0796

Please complete all sections of this claim form. Claims may be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be notified should additional information be required.

In order to be considered for payment:
International: Filing deadline is 365 days from the date of service.
U.S.: Please refer to your Certificate of Coverage document in www.myuhc.com.

Please complete a new and separate claim form for:
- Each patient • Each currency type • Each inpatient hospital stay
- Each different healthcare provider (unless multiple invoices with provider information are attached)

Questions? Call Customer Care: CCNum1 OR **CCNum2.**
UnitedHealthcare Global will accept calls from a relay service for the hearing impaired.

Section 1 – Patient Information

Member ID ☐☐☐☐☐☐☐☐☐ Group number ☐☐☐☐☐☐☐

Name (Last, First, MI) _____ Date of Birth ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

Gender: ○ Male ○ Female

Relationship to Subscriber/Policyholder: ○ Subscriber/Policyholder ○ Spouse/Partner ○ Child ○ Other Dependent

Phone # _____ Email address _____

Street _____ Town/city _____

Region/State _____ Country _____ Postal Code _____

Is the patient covered under another insurance health plan? ○ Yes ○ No If Yes: Name address and phone number of other insurance carrier:

_____

Reimburse: ○ Member ○ Provider ○ Other If Other selected, please provide name _____

If reimbursement is to provider or other, please provide your signature here _____

Section 2 – Member Reimbursement Options

(In order to save you time, you may access **www.myuhc.com** to verify and securely update your banking and currency preference.)

Note: If no selection is made, reimbursement will be via a U.S. dollar check.

○ Use previously provided banking details ○ Payment by check ○ Electronic funds transfer payment

*Please check current payment preference on file prior to selection

Bank Name _____ Account Name/Payee _____

Bank Branch Address _____

SWIFT/BIC Code _____ IBAN _____

Beneficiary bank routing/Sort code _____ Account Number _____

Would you like to keep the banking details above on file for future reimbursements? ○ Yes ○ No

Section 3 – Claim Information

Provider/facility name _____

Provider/facility full address _____

Where did the treatment take place? City _____ Country _____

Section 3 – Claim Information (cont.)

Type of Treatment	Description of Illness	Date of Service (mm/dd/yy)	Amount billed	Currency

Are the services provided related to an accident? ○ Yes ○ No

Type of Accident: ○ Work ○ Auto ○ Other _____ Date of accident (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

I authorize my physician to release medical information and records necessary to process this claim.

Signature _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Patient Signature (or Legal Representative)

Section 4 – To Be Completed by Treating Physician for Any Services Listed Below

Type of care: ○ Inpatient Admission ○ Outpatient surgery ○ Diagnostic Testing ○ Home Health Care ○ Injectable Medications ○ Radiation Therapy ○ Chemotherapy ○ Outpatient Therapy

Complete Applicable Information Below (Please Print)

Diagnosis _____ Date symptoms first started (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Physical Evaluation _____

Physician's Orders or Prescription _____

Diagnostic Test Results _____

Prior History Treatment _____

Co-morbid Conditions _____

Physician's notes/Comments _____

_____

_____

Physician Name (please print) _____ Medical Profession _____

Phone number (with country code) _____ E-mail _____

Physician's Full Address _____

Country _____

Signature of Treating Physician _____ Date ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature _____

Member/Legal Guardian
Signature of Minor Member or Member's Representative

Print Name _____

Relationship to Member _____

Date ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

Please maintain a copy of this document for your records.

UnitedHealthcare® Global