**Group Medical Direct Claim Form**

**UCAR**

**PPO Medical Plan**

**FAMILY/OTHER COVERAGE INFORMATION:** Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect

**EMPLOYEE’S/PATIENT’S SIGNATURE AND RELEASE:** Employee Must Sign all Claims

**NOTE:** If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

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<table>
<thead>
<tr>
<th><strong>EMPLOYEE INFORMATION:</strong> Employee Complete This Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. EMPLOYEE’S NAME (First, M.I., Last)</td>
</tr>
<tr>
<td>D. EMPLOYEE’S MAILING ADDRESS (Street, City, State, Zip) and DAYTIME PHONE #</td>
</tr>
<tr>
<td>E. EMPLOYEE’S SOC. SEC./ID NO.</td>
</tr>
<tr>
<td>F. MARITAL STATUS</td>
</tr>
<tr>
<td>G. POLICY/ACCOUNT NO.</td>
</tr>
<tr>
<td>H. DIVISION/BRANCH OR CLASS/LOCATION</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PATIENT INFORMATION:</strong> Complete Only if Patient is Other Than Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. PATIENT’S NAME (First, M.I., Last)</td>
</tr>
<tr>
<td>E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD</td>
</tr>
<tr>
<td>F. HEALTH CARE PROVIDER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:</strong> Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. DESCRIPTION OF ACCIDENT OR ILLNESS (How, When, Where)</td>
</tr>
<tr>
<td>B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT</td>
</tr>
<tr>
<td>C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS</td>
</tr>
<tr>
<td>D. INJURY DUE TO AUTO ACCIDENT</td>
</tr>
<tr>
<td>E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE A CLAIM FOR WORKERS’ COMPENSATION BENEFITS?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>FAMILY/OTHER COVERAGE INFORMATION:</strong> Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. SPouse EMPLOYED</td>
</tr>
<tr>
<td>B. NAME OF SPouse</td>
</tr>
<tr>
<td>C. SPouse’S SOC. SEC./ID NO.</td>
</tr>
<tr>
<td>D. NAME, ADDRESS AND PHONE # OF SPouse’S EMPLOYER</td>
</tr>
</tbody>
</table>

**MAIL THIS FORM TO:** THE ADDRESS SHOWN ON YOUR ID CARD.
Physician or Provider: Complete This Section

Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.

1.  
2.  
3.  
4.  

Place of Service

A. Date of Service

B. Procedure Code

C. Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given

(Explain unusual services or circumstances)

D. ICD-9 Diagnosis Code

E. Charges

Your Patient’s Account No.

Physician or Provider’s Tax Identification Number or Social Security Number to be Used for Tax Reporting.

Tax I.D. #

SOC. SEC. #

Physician or Provider’s Name and Address

Total Charge

Amount Paid

Balance Due

I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.

Physician or Provider’s Signature

Date

Inpatient Hospital

Outpatient Hospital

Doctor’s Office

Nursery Home

Skilled Nursing Facility

Night Care Facility

Ambulance

Other Medical Facility

Other Places

INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

You should submit your claims monthly or when you have bills totaling more than $200.00; but you must use a separate claim form for each member of the family.

1. IMPORTANT

- A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- Your claim cannot be processed without your Social Security Number (Employee Section, Block E).
- You must sign and date your claim form (Employee’s / Patient’s Signature and Release Section).

2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .

Surgery

Doctor’s Visit

Mental Illness Expenses

Hospital Confinement

Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).

3. IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:

- All Bills

- Drug Bills

(Please tape to an 8 1/2” x 11” piece of paper)

Employee Name

Date of Service

Patient Name

Prescription Date

Patient Name

Diagnosis

Physician Name

Drug Name

Type of Service

Charge for Service

Prescription Number

Charge

- Be certain to include Physician or Tax Identification number.
- Bills will not be returned to you - make copies for your records.
- Receipts, balance due statements and cancelled checks are not acceptable.

4. ADDITIONAL INFORMATION

Save your Explanation of Benefits - duplicate vouchers are not available.

Second Opinion Surgical Program - Call your benefits counselor for details.

5. MAILING INSTRUCTIONS

Send your completed claim form and itemized bills to the address indicated on the front of this form.