EPISCOPAL CHURCH MEDICAL TRUST

UnitedHealthcare
A UnitedHealth Group Company

Hearing Benefit Reimbursement Claim Form

Guidelines for Submitting Hearing Benefit Claims to UnitedHealth Group

- This form is only for submission of charges related to Hearing Benefits. Please take this form with you when receiving services.
- MAIL **claim form, bill and receipt** to: **United Healthcare, Atlanta Service Center, PO Box 740827, Atlanta, GA 30374**
- Be sure to notify your employer of any address change.
- Please include your UnitedHealthcare Member ID Number or SSN and Date of Birth on any attached receipts.
- If Diagnosis Code is not available, please use **H90.2**
- For member reimbursement claims, if provider Tax ID not provided, use default Tax ID number is **069000005**

A. PATIENT INFORMATION: Patient Completes This Section

Last Name:	First Name:	MI:	Date of Birth: / /
Member ID Number or SSN on UnitedHealthcare ID Card:	Policy Number: **706797**	Phone: ( )	
Home Address:			New Address: ☐ Yes ☐ No
City:	State:		Zip Code:

B. RETIREE INFORMATION: Δ Check here if same as Patient

Last Name:	First Name:	MI:	Date of Birth: / /
Member ID Number or SSN on UnitedHealthcare ID Card:	Policy Number: **706797**	Phone: ( )	
Home Address:			New Address: Yes No
City:	State:		Zip Code:

C. PHYSICIAN OR PROVIDER: Complete This Section

Right/Left Ear	Diagnosis (H90.2 if not available)	Date of Service	**INTERNAL USE ONLY** Place of Service	Procedure Code	Charges
RIGHT			FS	V5256	
LEFT			OL	V5256	

Reimbursement Type:

⌋ **Pay to Member** Δ **Pay to Provider**

Please have physician/provider fill out the information below:

Physician or Provider's Tax ID Number:	Total Charge:
(Internal use only: Keyer, if Tax ID is not provided please use UHC Tax ID 069000005 for member reimbursement only)	Patient Amount Paid:
Physician or Provider's Address:	Balance Due:

Physician or Provider's Telephone Number: ( )

Physician or Provider's Signature:______________________________________ Date:____________________

D. MEMBER SIGNATURE Certification for Reimbursement

I certify that any expenses for which I am requesting reimbursement, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for care as permitted under the Hearing Aid plan, and have not been reimbursed and I will not seek reimbursement under any other plan. To the best of my knowledge and belief, my statements are complete and true. I authorize the release of any medical or other information necessary to process this claim. 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.

Member Signature:____Date: ____________________________________