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 the claim form and proof of payment to: **United Healthcare, Atlanta Service Center, PO Box 740827, Atlanta, GA 30374**
- Submit the bill, claim form and the receipt showing payment to: UnitedHealthcare
- 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.

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: ☐ 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	Date of Service	**INTERNAL USE ONLY** Place of Service	Procedure Code	Charges
RIGHT			FS	HAD	
LEFT			OL	HAD	

Reimbursement Type:
☐ **Pay to Member** ☐ **Pay to Provider**

Please have physician/provider fill out the information below:	Total Charge:
Physician or Provider's Tax ID Number:	Patient Amount Paid:
(Internal use only: Keyer, if Tax ID is not provided please use UHC Tax ID 069000005 for member reimbursement only)	
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: _____