univera HEALTHCARE
an excellus company

205 Park Club Lane, Buffalo, NY 14221

[redacted]

Subscriber Claim Form

Mail Completed Claims To: **Univera Healthcare**
PO Box 211256
Eagan, MN 55121-2656

Subscriber identification number:

Subscriber's Full Name

Address

City, State, Zip Code

If your address has changed or is incorrect, please call our Customer Service Department as instructed on the back of the form.

1. Patient Information:

Patient's full name:

Sex: ☐ Male ☐ Female

Relationship to subscriber: ☐ 1. Self ☐ 3. Child ☐ 2. Spouse ☐ 4. College Student

Patient's date of birth: | |

If treatment was the result of a non-work injury, give date of injury: | |

If other than USA, in what country was patient treated?

Patient diagnosis *(illness/injury which required treatment):*

2. Medicare:

Regardless of age, if the patient is covered by Medicare, please be sure to send bills and matching "Explanation of Medicare Benefit".

3. Motor Vehicle or Work Related Illness or Injury:

a. Was the treatment in any way motor vehicle related? . . . . . ☐ YES ☐ NO

b. Was the treatment the result of a work related illness or injury? . . . . . ☐ YES ☐ NO

c. If answer to a. or b. is yes, please describe accident or illness:

Date of accident or illness: | |

Check If:

☐ **I have other Insurance.**

☐ **My other Insurance has changed.**

4. Other Insurance Carrier:

If the patient is covered by another health care plan:

If we are your secondary insurance, please be sure to send itemized bill and matching Explanation of Benefit form(s) from the other insurance company.

Policyholder's name:	Date of birth:	Social Security number:	Relationship to patient:
Name of policyholder's employer:			Employment status: ☐ Active ☐ Retired
Name and address of insurance carrier:			This policy covers the: ☐ Individual ☐ Husband & Wife ☐ Family ☐ Parent & Child
Policy or certificate number:	Effective/Cancellation date:	Carrier's telephone number:	Spouse's date of birth:

5. Claim Date and Subscriber Signature: *(Unsigned claims will be returned.)*

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information requested relevant to this claim and any attached bills.

Date: | | Subscriber's signature:

How To Submit Your Claim

This claim form can be used to submit all your bills. However, a separate claim form must be completed for each person's bills.

If you need additional claim forms or have any questions about completing the claim form or benefits covered under your contract, please contact us at the number listed on your identification card.

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In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. Submit bills for each patient on separate claim forms. A separate claim form is also required for different calendar years. Please submit the original bills with your claim form. Keep copies for your own records. The actual bills are necessary for claims processing.

B. Itemized bill(s) for services or supplies must be submitted with this form in order for reimbursement to be considered. The itemized bill must clearly indicate all of the following:

Name and address of the provider of service on their office letterhead, including provider credentials and EIN (TAX) and NPI numbers.

Patient's full name and date of birth.

Valid procedure code (description of services rendered) for each charge

Place of service (inpatient or outpatient hospital, office, etc.).

Date for each service rendered.

Charge for each service rendered.

Valid diagnosis code (description of illness/injury for services rendered).

County must be indicated and all information translated to English for any services not rendered in the USA.

C. Bills for the following services should also include:

FOR THOSE CONTRACTS WITH PRESCRIPTION DRUG COVERAGE - Prescription number, name ofdrug, and name of prescribing doctor is required.

Private Duty Nurse - The type of Nurse (RN or LPN), license number, the shift and hours worked. A statement of medical necessity from the prescribing doctor.

Durable Medical Equipment (wheelchair, oxygen tank, etc.) - A statement of medical necessity from theprescribing doctor which indicates how long the equipment will be used and a statement from the equipment supplier showing both the rental and purchase price.

D. Cash register receipts, canceled checks, money orders, credit card vouchers and personal lists ofservices or bills stating only 'balance forward' are not acceptable as substitutes for bills.

Our employees are dedicated to prompt and accurate claim payments to our subscribers. By following these instructions and filling out the claim form completely, you will help us meet our goal of processing your claim in a satisfactory manner.