

PLEASE DO NOT STAPLE IN THIS AREA

United Behavioral Health Claims
PO Box 30755
Salt Lake City, UT 84130-0755



HEALTH INSURANCE CLAIM FORM

Form with multiple sections: 1. PICA, 2. PATIENT'S NAME, 3. PATIENT'S BIRTH DATE, 4. INSURED'S NAME, 5. PATIENT'S ADDRESS, 6. PATIENT RELATIONSHIP TO INSURED, 7. INSURED'S ADDRESS, 8. PATIENT STATUS, 9. OTHER INSURED'S NAME, 10. IS PATIENT'S CONDITION RELATED TO?, 11. INSURED'S POLICY GROUP OR FECA NUMBER, 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE, 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE, 14. DATE OF CURRENT ILLNESS, 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, 16. DATES PATIENT UNABLE TO WORK, 17. NAME OF REFERRING PHYSICIAN, 18. HOSPITALIZATION DATES, 19. RESERVED FOR LOCAL USE, 20. OUTSIDE LAB?, 21. DIAGNOSIS OR NATURE OF ILLNESS, 22. MEDICAID RESUBMISSION CODE, 23. PRIOR AUTHORIZATION NUMBER, 24. TABLE with columns A-K, 25. FEDERAL TAX I.D. NUMBER, 26. PATIENT'S ACCOUNT NO., 27. ACCEPT ASSIGNMENT?, 28. TOTAL CHARGE, 29. AMOUNT PAID, 30. BALANCE DUE, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, 32. NAME AND ADDRESS OF FACILITY, 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION