UnitedHealthcare®
A UnitedHealth Group Company

M.D. IPA℠ OPTIMUM CHOICE® MAMSI® LIFE AND HEALTH INSURANCE COMPANY

Member Claim Submission Form

P.O. Box 948 • Frederick, MD 21705-0948

MEMBER INFORMATION

Patient's Social Security Number			Patient's Member Number		
Patient's Name (Last)	(First)	(M.I.)	Subscriber's Name (Last)	(First)	(M.I.)
Patient's Address if Different than Subscriber's			Subscriber Address		

Patient's Date of Birth	Patient's Sex	Patient's Relationship to Subscriber	Telephone Number
	☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	

NATURE OF ILLNESS/ACCIDENT

Nature of Illness or Injury (state when, where and how it occurred)

Did you have a referral for these services? Yes No

Is illness/accident related to employment? Yes No Auto accident? Yes No Other accident? Yes No

OTHER HEALTH INSURANCE INFORMATION

Please complete if the patient is covered by additional health care coverage through an employer, a group such as a professional organization, or any other health plan.

Name and Address of Carrier (please include street address, city, state and ZIP)	Policy Number

PROOF OF PAYMENT

Member will only be reimbursed if acceptable proof of payment is submitted with claim.

For Patients: Acceptable proof of payment includes cancelled checks or receipts from the provider(s) of service.
For Hospitals: All hospital submissions must be itemized on a UB92 Form with proof of payment (Box 54) completed.
For Physicians: All physician submissions must be itemized on a HCFA/CMS 1500 Form with proof of payment (Box 29) completed.

Note: A cancelled check would show proof of payment, but is not in itself sufficient. An itemized bill should also be submitted and must have the patient name and member number, provider name and address, description of services (CPT Codes), date of service, amount of charge and diagnosis.

ASSIGNMENT OF BENEFITS (If signed, payment will be made directly to provider)

I hereby authorize payment directly to the provider of services. All benefits are payable after applicable copayments according to the description in the patient's Evidence of Coverage. I understand that I am financially responsible to the provider for charges not covered by this assignment. However, if a claim is not submitted with proof of payment, benefit payment will be made directly to the provider of services. Payment for services rendered by a non-participating provider will be sent directly to the patient when the group is subject to non-assignment policies as established by UnitedHealthcare.

Signed _____ Date _____

For Physicians: All physician submissions must be itemized on a HCFA/CMS 1500 Form with Box 12 completed.
For Hospitals: All hospital submissions must be itemized on a UB92 Form with Box 53 indicating "Y" for assignment.

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Subscriber, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

Subscriber Signature _____ Date _____

Patient Signature _____ Date _____

HOW TO FILE A CLAIM

All claims must be submitted within 180 days of service(s) date.

Please PRINT all information.

Separate your bills by patient. You will need a different claim form for each patient.

Staple your claims to your claim form.

Assemble all itemized health care bills, a HCFA/CMS 1500 claim form is preferred.

If you have other coverage, you must fill out the "Other Health Insurance Information" section and provide copies of any Explanation of Benefits that apply to the claims being submitted.

Send only **ORIGINAL** bills and retain a copy for yourself.

ORIGINAL itemized bill(s) from each health care professional must be included and must contain all of the following information:

1. Letterhead indicating the person or organization providing the service, their address and provider Tax Identification number.
2. The name of the patient receiving the service.
3. The service date.
4. The charges for each service.
5. A description and CPT code for each service.
6. The place the service was received.
7. Signature of provider.
8. The diagnosis.

For Behavioral Health Services, you must include the session length, type and provider's professional status.

Mail completed claim form and **ORIGINAL** bills to:

United Healthcare (formerly MAMSI)
P.O. Box 948
Frederick MD 21705-0948

NOTE: When receiving care from a Participating Provider, payment will be sent to the Participating Provider.