Shell Oil Company
Group # 182232

UNITEDhealthcare℠
P.O. BOX 30555
Salt Lake City, UT 84130-0555

HEALTH CLAIM TRANSMITTAL MEDICAL AND DENTAL

Employee Name:_____ SSN: ___-___-___Date of Birth: ___/___/___

Check If
Employee Address:_____ New Address | |

Employee Phone Number: (___)_____ Status: Active Retiree (COBRA)
Area Code Number

Spouse Name: _____Spouse Date of Birth: ___/___/___

Patient Name: _____Date of Birth: ___/___/___ Relationship: _____

Nature of Illness of Injury: _____

_____
IF CLAIM IS DUE TO INJURY STATE WHEN, WHERE AND HOW INJURY OCCURRED

Do You Have Coverage Through Another Employer? Yes No

Is Your Spouse Employed? Yes No Is Patient Employed? Yes No

If you answered "yes" to any of the above questions, please provide the following information:
Employed Person: _____ Social Security Number: ___-___-___

Employer: _____

Employer Address: _____Phone Number (___)_____
Area Code Number

Insurance Company & Policy Number: _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OR 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.

Employee Signature: _____ Date: ___/___/___

HINTS FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- ***If you want United HealthCare to pay benefits directly to the provider of medical services, write "pay directly" prominently on the bill(s).***
- *Attach your bills to this completed form and mail them to United HealthCare at the address shown above. COBRA continuees mail this to the United HealthCare claim office you used as an active employee (or as a dependent of an active employee).*
- *Make sure all bills indicate the reason (diagnosis) for treatment and list the date, type and cost of each service.*
- *Send additional bills periodically or when they total $50.00 or more.*

FOR UNITED HEALTHCARE USE ONLY

DATE BENEFITS BECAME EFFECTIVE
DATE BENEFITS TERMINATED
SUFFIX ACCOUNT

SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:

DATE:

Retail Claim Receipts - UnitedHealthcare

Please tape your receipts here. **Please do not staple!**

Tape receipt for Rx 1 here

Tape receipt for Rx 2 here

Receipts must contain the Following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name and address
- NDC number (Drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- Amount paid

Tape receipt for Rx 3 here

Tape receipt for Rx 4 here

Direct Reimbursement Claim Instructions:

1. Always present your prescription ID card at the participating retail pharmacy.

2. If you have a primary insurance carrier, please submit these charges to them for consideration.

3. Claims must be submitted with 18 months of the date of purchase.

4. Be sure that your receipts are complete. They must contain all the information listed above.

5. The Plan Member should review the information on the front of this form completely, then sign and date the form.

6. Return the completed form and receipts to:

   UnitedHealthcare
   P.O. Box 30555
   Salt Lake City, UT 84130-5555