

HEALTH CLAIM TRANSMITTAL

Synopsys, Inc.

Group Number - 701403

UnitedHealthcare®

P.O. Box 30555

Salt Lake City, UT 84130-0555

Customer Service: 866-351-6804

A. MEMBER/EMPLOYEE INFORMATION

Member # (SSN): --- ---		Phone #: ()	
Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:			New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>
City:	State:		Zip Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth: / /

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:			Zip Code:
City:	State:		Zip Code:
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relationship To member:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: ()

C. ACCIDENT INFORMATION

Work Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the Accident Occur:		

D. OTHER INSURANCE

Is the patient covered By another plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please complete the following
Name of the person Carrying other insurance:	Date of Birth: / /	
SSN #:	Name of Other Insurance Carrier:	
Policy Number:	Employer Name:	
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: _____

E. ASSIGNMENT OF BENEFITS

Please sign below <i>only if you want UnitedHealthcare to pay benefits directly to the provider</i> of medical services.	
Member Signature: _____	Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITED HEALTHCARE

- Clip, do not staple, all bills to the completed form and mail them to UnitedHealthcare at the address above.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include you Member Number on all documents.