UnitedHealthcare Global Expatriate Insurance Claim Form

Return this form with a copy of the bill(s) or receipt(s) online, via mobile app, fax or mail.

Claim Type(s): ○ Medical ○ Dental ○ Vision ○ Pharmacy/Rx

Online	Mobile	Fax	Mail
www.myuhc.com	Download the Health4Me mobile app	+1-877-370-4150 +1-813-870-0796	UnitedHealthcare Global PO Box 740111 Atlanta, GA 30374-0111

Please complete all sections of this claim form.

Claims may be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be notified should additional information be required.

In order to be considered for payment:

International: Filing deadline is 365 days from the date of service.

U.S.: Please refer to your Certificate of Coverage document in www.myuhc.com. If you receive services from a U.S. in-network provider with reimbursement paid directly to the provider, filing deadine is subject to the provider's filing limit.

Please complete a new and separate claim form for:

- Each patient
- Each currency type
- Each inpatient hospital stay
- Each different health care provider (unless multiple invoices with provider information are attached)

Questions? Call the Customer Care phone number on the back of your Member ID Card.
UnitedHealthcare Global will accept calls from a relay service for the hearing impaired.

Section 1 – Patient Information

Member ID ☐☐☐☐☐☐☐☐☐ Group Number ☐☐☐☐☐☐☐

Name (Last, First, MI) _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Gender: ○ Male ○ Female

Relationship to Subscriber/Policyholder: ○ Subscriber/Policyholder ○ Spouse/Partner ○ Child ○ Other Dependent

Phone Number _____ Email Address _____

Street _____ Town/City _____

Region/State _____ Country _____ Postal Code _____

Is the patient covered under another insurance health plan? ○ Yes ○ No If Yes: Name address and phone number of other insurance carrier:

_____

Section 2 – Member Reimbursement Options

(Visit **www.myuhc.com** to verify and securely update your banking and currency preference.)

Note: If no selection is made, reimbursement will be via a U.S. dollar check.

○ Use previously provided banking details* ○ Payment by check ○ Electronic funds transfer payment

○ One time reimbursement request (policy holder and dependents 18 years of age older)

*Please check current payment preference on file prior to selection

Bank Name _____ Account Name/Payee _____

Bank Branch Address _____

Local ID or Passport (as applicable) _____ SWIFT/BIC Code _____ IBAN _____

Beneficiary Bank Routing/Sort Code _____ Account Number _____

Would you like to keep the banking details above on file for future reimbursements? (This option is only available to policy holders.) ○ Yes ○ No

Section 3 – Claim Information

Provider/Facility Name _____

Provider/Facility Full Address _____

Provider Phone Number _____ Email Address _____

Where did the treatment take place? City _____ Country _____

Type of Treatment	Diagnosis/Description of Illness or Accident	Date of Service (mm/dd/yy)	Amount Billed	Currency

Are the services provided related to an accident? ○ Yes ○ No

Type of Accident ○ Work ○ Auto ○ Other _____ Date of Accident (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

I authorize my physician to release medical information and records necessary to process this claim.

Signature _____ Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Patient Signature (or Legal Representative)

By signing below, I am stating that the information above is correct. 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.

Signature _____

Member/Legal Guardian
Signature of Minor Member or Member's Representative

Print Name _____

Relationship to Member _____

Date ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Please maintain a copy of this document for your records.

UnitedHealthcare® Global