Dental insurance claim form

Return this form with a copy of the invoice via email, fax or mail.

Email

expatinsurance_memberservices@uhcglobal.com

Fax

+1.877.370.4150
+1.813.870.0796

Mail

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 myuhc.com®. If you receive services from a U.S. in-network provider with reimbursement paid directly to the provider, filing deadline 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 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		

continued

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Section 2 – Member reimbursement options

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 (policyholder and dependents 18 years of age older)

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 policyholders.) ☐ 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	Print name
Member/legal guardian Signature of minor member or member's representative	Relationship to member
	Date (mm/dd/yyyy)

Please maintain a copy of this document for your records.

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