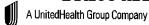
American Airlines®





P.O. Box 30551 Salt Lake City, UT 84130-0551

A. MEMBER/EMPLOYEE INFORMATION Phone #: Member # (SSN): Last First MI: Date of Birth: Name: Name: New Home Address: Address: Yes ☐ No□ City: State: Zip Code: First MI: Spouse Date of Birth: Spouse Last Name: Name: **B. PATIENT INFORMATION** MI: First Date of Birth: Last Name: Name: Home Address: State: Zip City: Code: Sex: M□F□ Full Time Student: School Phone #: Relationship School to Member: Yes□ No□ C. ACCIDENT INFORMATION Work Auto Date Accident Accident: Accident: Yes □ No □ Yes □ No □ Occurred: How did the accident occur? D. OTHER INSURANCE Is the patient covered by another insurance plan? Yes ☐ No ☐ If yes, please complete the following: Date of Birth: Name of person carrying other insurance: SSN#: Name of Other Insurance Carrier: Policy **Employer** Number: 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 only if you want UnitedHealthcare to pay benefits directly to the provider of medical services.

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- 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.

Member Signature:

Please include your Member Number on all documents.

100-3165 (11/00) MD1968.GRN(23513)

Date: