



PHARMACY COPAY TRANSMITTAL

UnitedHealthcare®



A UnitedHealth Group Company

PO Box 740800
Atlanta, GA 30374-0800

Suffolk School Employees Health Plan
Policy Number: 710635
Customer Service Toll-Free Number: 866-844-4864

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or 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:			
City:	State:		Zip Code:
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Subscriber:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: School Phone #: () ()

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 insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:	
Name of 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.

Subscriber Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

Please sign below *only if you want UnitedHealthcare to pay benefits directly to the provider* of medical services.

Subscriber Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO UNITEDHEALTHCARE

- RX Copay reimbursements are available for dependents of SSEHP employees who have primary coverage under another plan/carrier
- Please submit the pharmacy receipts with this claim form (cash register receipts not acceptable)
- Claim form and pharmacy receipts should be mailed to the address at the top of this form
- DO NOT sign section E unless you want payment to go directly to the Pharmacy.