MEDICAL CLAIM FORM

Please fill in all information legibly and completely.

PATIENT NAME	**PATIENT'S BIRTHDATE**		
MEMBER NAME	**PATIENT RELATIONSHIP TO MEMBER**		
MEMBER ID#	**PHONE NUMBER**		
MEMBER HOME ADDRESS	**CITY**	**STATE**	**ZIP**
DATE OF SERVICE	**IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN? WORK REALATED? YES NO**		
IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN? YES NO **POLICY NUMBER** **NAME AND ADDRESS OF OTHER INSURANCE COMPANY**			

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any insurance company, prepayment organization, employer hospital, or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under thisor any other plan provider benefits or services. I hereby certify the information provided is correct and to the best of my knowledge.

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Signature of Patient or Parent (if patient is a minor) Date

See Page 2 for instructions on how to file a claim.

PROCEDURE FOR FILING A CLAIM

1. Please attach all medical bills relating to the claim(s). Missing or incomplete claim information could delay processing and reimbursement.
    a. Make sure the bills identify the patient.
    b. All bills should show the date of treatment, description of service and amount of charges.
    c. **Procedure Codes and Diagnosis codes must be included or claim form will be returned**.
    d. All statements should have your identification number listed.
    e. Mail to: University of Utah Health Plans PO
        Box 45180
        Salt Lake City, UT 84145-0180
    f. Or fax to 801-281-6121 ATTN: Member Reimbursement
    g. Or email to memberservice@mhc.coop
    h. Please call customer service for any questions: 1-855-447-2900.