

International Claims Transmittal



Return this form with the original medical bill or claim form via mail or fax to:

UnitedHealth Group
 International Claims
 PO Box 740817
 Atlanta, GA 30374

| | |
|--------------------------|---|
| <input type="checkbox"/> | Check here if this is a repeat submission |
|--------------------------|---|

Please complete all sections of this transmittal 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 advised in writing should additional information be required.

Please complete a new & separate claim transmittal form for:

- * Each patient * Each inpatient hospital stay * Each different healthcare provider * Each currency type

Section 1 – Member & Patient Information

Check one: ___ I am an Expatriate or retiree living abroad. ___ I am traveling internationally for pleasure.
 ___ I am traveling internationally for business, however, live in the U.S.

| | | | |
|--|--|---|--|
| Group Name | | Group Policy # | |
| Member Name | | Member id # | |
| Patient Name | | Patient Relationship | |
| Patient Date of Birth | | Member Phone # | |
| Is the patient covered under another Medical Health Care Plan? ___ Yes ___ No | | | |
| Member's Return Correspondence Address | Street Town/city Area postal code Region Country | | |
| In which country did the treatment take place? | | | |
| What type of currency is the bill submitted in? | | | |
| What is the total amount of the claim in U.S.Dollars? (opt) | | | |
| Please check the type of service that was rendered: <input type="checkbox"/> Office visit <input type="checkbox"/> Inpatient hospital care <input type="checkbox"/> Inpatient surgery <input type="checkbox"/> Outpatient surgery <input type="checkbox"/> Emergency room visit <input type="checkbox"/> Lab or X-ray services <input type="checkbox"/> Prescription drugs covered under your UHC plan <input type="checkbox"/> Medical supplies <input type="checkbox"/> Other _____ | | Date of service(s): _____ A brief explanation of the purpose of your healthcare provider visit; including services rendered and/or procedures performed: | |

Section 2 – Healthcare Provider Contact Information

| | | | |
|---|------------------|-----------|--|
| Name of Healthcare Provider | | | |
| Name of facility or hospital | | | |
| Address | Street | Town/city | |
| | Area postal code | Region | |
| | Country | | |
| Telephone number (including 2-digit country code) | | | |
| Fax number (if available) | | | |

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: _____

Continued on reverse side

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Section 3 – Important Information for Submitting Your Medical Claim

- ***Faxing a Claim*** - Illegible faxes received in our mailroom will be returned to you via the fax number used to send the document to us. Therefore, when faxing correspondence to us, please make sure you use a fax machine where you can also receive correspondence.
- Submitting original documents is always helpful in expediting the processing of your claim. When possible, send the original claim, itemized bill, and medical records. This is especially helpful for inpatient hospital bills. ***Always remember to keep a copy of all documentation for your records.***
- If possible, ask the provider of service to write the bill in English and convert the currency to U.S. Dollars.
- If the provider of service is not able to present the bill or claim in English and U.S. Dollars, do not perform the translation and currency exchange yourself. United Healthcare will provide these services for you.
- Remember that all plan-filing rules apply to international claims. Submit your claims as soon as possible after treatment is rendered.
- If payment is to be issued to you, please submit a proof of payment. A cancelled check, cash receipt, charge receipt, or handwritten receipt from the medical provider is acceptable.
- If you have a U.S. address for the receipt of mail, please make sure that your employer is aware of this address so they may supply it to us for the mailing of your check and/or explanation of benefits.
- International bills can be more complicated than a regular U.S. bill due to language and currency conversion and/or the receipt of additional information required to process the claim. As a result, it may take longer to process your claim.
- Your international claim payment information is available on www.myuhc.com. Please use this as a resource when checking the status of your claim.
- If a reasonable amount of time has passed, and after checking www.myuhc.com for the status of your claim, you still have questions regarding the status or payment of your claim, please call the Member Services number on the back of your ID card.

Note for non-medical or non-UHC claims (ie: Dental, Medco Rx, etc.) – this is not the process for submitting your international bill. Please contact the Member Services number located on the applicable member id card.

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Member signature _____ Date: _____