UHC Claims Submission Template
Claim Information:
- Claim Number: [Insert Claim Number]
- Date of Service: [Insert Date]
- Provider Name: [Insert Provider Name]
- Provider NPI: [Insert Provider NPI]
- Patient Information:
 - Patient Name: [Insert Patient Name]
 - Date of Birth: [Insert DOB]
 - Member ID: [Insert Member ID]
Diagnosis Information:
- Primary Diagnosis Code: [Insert ICD Code]
- Secondary Diagnosis Codes: [Insert ICD Codes if applicable]
Procedure Information:
- CPT/HCPCS Code: [Insert Procedure Code]
- Description of Service: [Insert Description]
Billing Information:
- Total Charges: [Insert Amount]
- Amount Paid: [Insert Amount]
- Patient Responsibility: [Insert Amount]
Attachments:
- Itemized Bill: [Attach PDF or Document]
- Medical Records: [Attach PDF or Document]
- Supporting Documentation: [Attach PDF or Document]
Provider Signature:
- Signature: [Provider Signature]
- Date: [Insert Date]
Contact Information:
- Provider Contact Name: [Insert Contact Name]
- Phone Number: [Insert Phone Number]
- Email Address: [Insert Email Address]
Submission Instructions:
- Submit Claims to: [Insert Address or Email]
- Submission Method: [Choose one: Electronic / Mail]
Notes:
- [Any additional notes or comments]