UHC Claim Request Template

Patient Information:

- Name: _____
- Date of Birth: _____
- Member ID: _____
- Address: _____
- Phone Number: _____

Provider Information:

- Provider Name: _____
- NPI Number: _____
- Address: _____
- Phone Number: _____

Service Details:

- Date of Service: _____
- Service Type: _____
- CPT/HCPCS Code: _____
- Diagnosis Code(s): _____

Claim Information:

- Claim Amount: _____
- Billing Date: _____
- Payment Method: _____
- Attachments: (Yes/No) _____

Signature:

- Signature of Patient: _____
- Date: _____

Notes:

1. Ensure all required codes are included.
2. Attach all relevant documents.
3. Submit to the appropriate UHC department.
