

University of Washington Graduate Appointee Plan

Underwritten by United HealthCare Insurance Company

UW HEALTH CLAIMS
 P. O. Box 34600, Seattle, WA 98124-1600
 (866) 535-8503 or (206) 374-9439

Instructions:

Please complete this form, attach all itemized bills, send to the Claims Office, and keep a copy for your records.

For Toll-Free Assistance Nationwide Call:
 WPAS Claims Office 1-866-535-8503 or (206) 374-9439

PART I - TYPE(S) OF CLAIM: Check type(s): Medical Dental Vision

PART II - APPOINTEE DATA: UW Student ID # _____

Appointee Name: _____ Social Security # _____
 (First Name) (Last Name) (MI)

Mailing Address: _____
 (Street) (City) (State) (Zip)

Spouse Name: _____ Social Security # _____

Is your spouse employed? Yes No If yes, please write name, address and telephone number of employer:

PART III - PATIENT DATA: Claim is for: Self Spouse Dependent Child Domestic Partner

Patient Name: _____ Birth Date: ____/____/____
 (First Name) (Last Name)

If claim is for dependent child, indicate relationship: Child Step Child Legal Guardianship Other _____

If child is age 19 or older, is child developmentally disabled or handicapped? Yes No

If yes, contact the Claims Office for instructions.

PART IV - OTHER INSURANCE INFORMATION:

Does patient have other health insurance coverage: Yes No If yes: Medical Dental Vision

Date other coverage began? _____ Date coverage will terminate? _____

Subscriber Name: _____ Subscriber SS#: _____

Insurance company/plan administrator's name, address, telephone #, policy/plan #:

PART V - CLAIM INFORMATION (complete only applicable information):

Are expenses related to an injury? Yes No If yes, indicate date of injury ____/____/____ and type of injury:

Automobile Home/Recreational Intercollegiate sport

Employment-Related: Name, address & telephone of employer: _____

Other _____

Briefly describe injury: _____

Note: If claim is related to an injury, you will receive an "accident questionnaire". Respond promptly to expedite claim processing.

PART VI - AUTHORIZATION TO PROCESS CLAIM:

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. **It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.**

I authorize benefit payment to the health provider for the services and/or supplies described on this claim form. Yes No

_____/____/____
 Appointee Signature Date

CLAIM FILING TIPS

WE WANT YOUR CLAIMS TO BE PAID ACCURATELY AND TIMELY. USING THE FOLLOWING TIPS WILL HELP US GIVE YOU BETTER SERVICE.

DOs

- Answer all the appropriate questions and sign the claim form.
- Always send your claim form and an itemized statement of charge which includes:
 1. Appointee name
 2. Patient name
 3. Provider name & Provider Tax ID number
 4. Dates of service
 5. Diagnosis (preferably with code number)
 6. Types of service (preferably with code number)
 7. Charges for each type of service
- Try to batch your claim submissions (send several itemized bills at one time). This will help us keep costs down.
- **If you have other insurance coverage**, please remember to submit the claim to the **other insurance plan first**. (Refer to your health benefit booklet, "Excess" Benefits Plan). When you receive the "explanation of benefits" statement back from the other plan, submit the claim to WPAS, include a copy of the bill and a copy of the other plan's EOB (explanation of benefits) statement.

Exception: The Claims Office will internally coordinate the processing of a claim, if both plans are administered by WPAS.

Mail Claims to:

UW/WPAS Claims Office
PO Box 34600
Seattle, WA 98124-1600
1-866-535-8503 or
(206) 374-9439

DON'Ts

- Never send a "balance forward bill" to the Claims Office.
- Make certain you know who is going to file your claim. Do not submit a claim yourself, if your health care provider tells you they will submit the claim for you. Duplicate claim filing adds to the administrative expense of operating our plan.