UHC makes it very easy for you to file Out of Network claims.
Attached are a couple of slides from our town hall meeting with that information. Additionally, here a list of questions you can ask UHC in regards to your out of network benefits. Also included is a the link for the claim form.
Feel free to contact us with any questions.

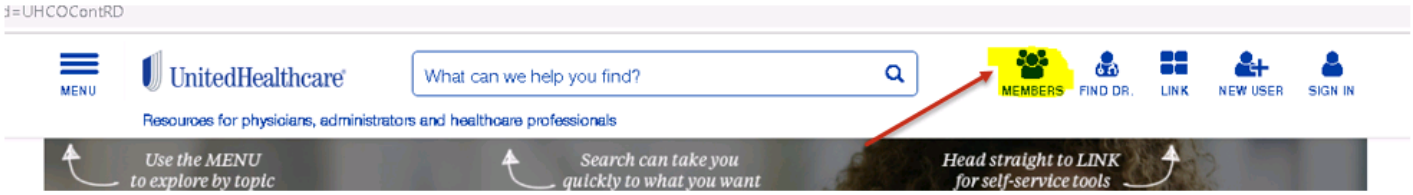
Questions to ask member services for out of network benefits:

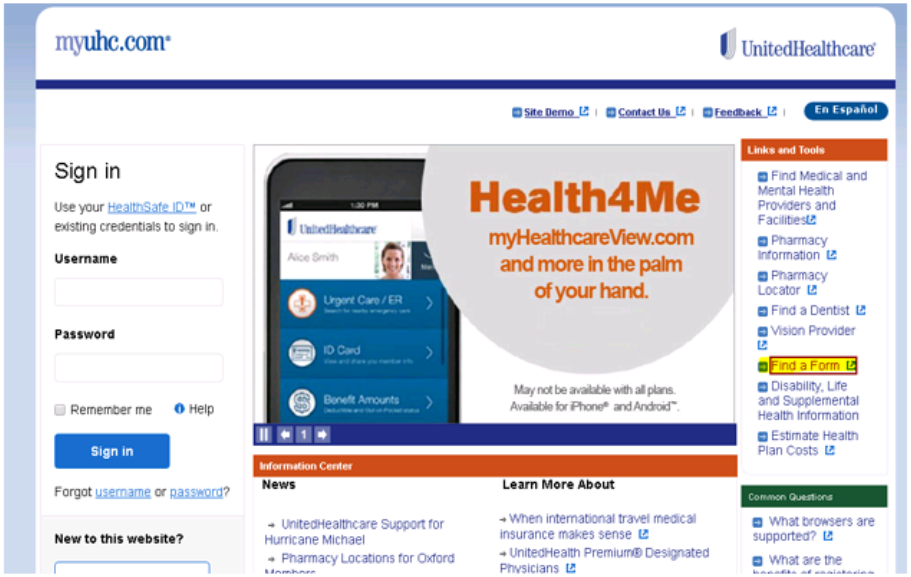
1. Do I have out of network benefits?
    a. If the answer in no, then ask if there is any way you could get reimbursed for services performed outside of the network (sometimes there might be exceptions).
    b. If the answer is yes to the question about out of network benefits, proceed with the following questions.
2. I would like get information about my coverage for out of network chiropractic services done in the office. Would you be able to help?
3. Is there a deductible to meet? If so, what is the deductible?
4. After I meet my deductible, is there a co-insurance?
5. Does my in-network deductible also apply to my out of network deductible?
6. Do I have an out of network out of pocket(OOP)?
7. Is this combined with my in-network OOP?
8. What is the reasonable and customary rate for my chiropractic services?
    a. They will probably need the following:
        i. TAX ID, NPI, CPT codes and ICD 10 codes.
    b. The specific information can be found on your services rendered receipt as well.
    c. Members services might also have this information from previous claims.
9. Is there a visit limit?
10. Are my visit limits based on medical necessity?
11. Are there any other limitations to chiropractic services?
12. How do I file a claim?
13. Is there a time limit for filing claims?
14. How soon can I expect a payment or explanation of benefits?

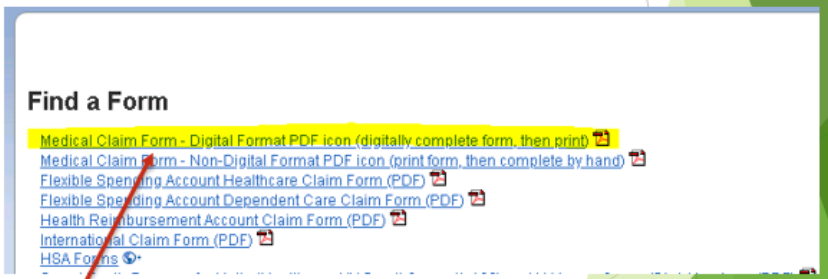
https://www.myuhc.com/content/myuhc/Member/Assets/Pdfs/Medical_Claim_Form_Non_Digital.pdf

Out of Network Claims United Health Care

- If you don't have an existing account with UHC, go to unitedhealthcareonline.com on your search bar. Then click on the members icon.
- Once on the members screen, click on forms. Then click on the Medical Claim

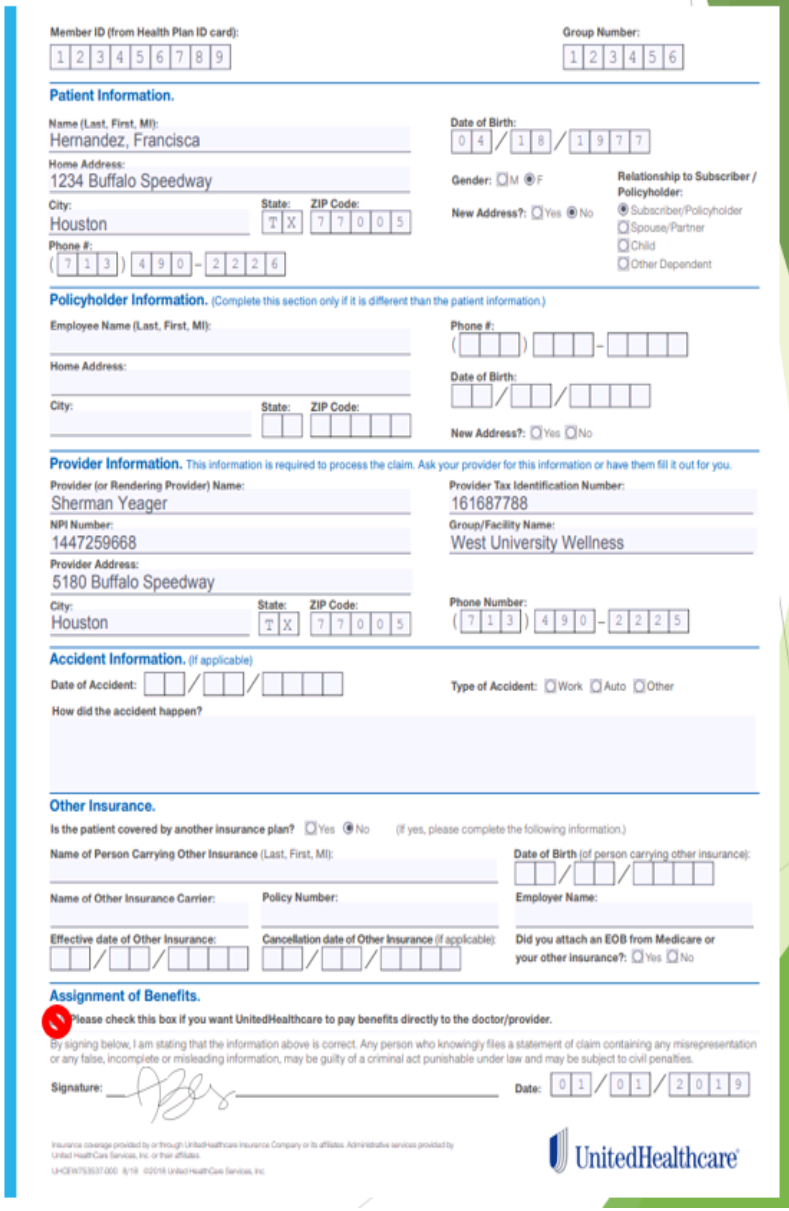






Out of Network Claims United Health Care

- The second page is your claim form.
- The top section is your information. Fill in your Member ID, Group number, Birthdate, Gender, Patient, and Policyholder information.
- The middle part of the form is the providers information.
- We can give you this information. It's available on your Services Rendered Statement.
- The accident and other insurance information only needs to be filled out if you've been in an accident and/or have other coverage.
- DO NOT sign the Assignment of Benefits. Your payment will not be sent to you.
- BE SURE to sign and date your form.
- Send this form along with the Services Rendered Statement we will give you.



Member ID (from Health Plan ID card): 123456789

Group Number: 123456

Patient Information.

Name (Last, First, MI): Hernandez, Francisca

Date of Birth: 04/18/1977

Home Address: 1234 Buffalo Speedway

Gender: ☐M ◉F

Relationship to Subscriber / Policyholder: ◉Subscriber/Policyholder ☐Spouse/Partner ☐Child ☐Other Dependent

City: Houston State: TX ZIP Code: 77005

New Address?: ☐Yes ◉No

Phone #: (713) 490-2226

Policyholder Information. (Complete this section only if it is different than the patient information.)

Employee Name (Last, First, MI):

Phone #:

Home Address:

Date of Birth:

City: State: ZIP Code:

New Address?: ☐Yes ☐No

Provider Information. This information is required to process the claim. Ask your provider for this information or have them fill it out for you.

Provider (or Rendering Provider) Name: Sherman Yeager

Provider Tax Identification Number: 161687788

NPI Number: 1447259668

Group/Facility Name: West University Wellness

Provider Address: 5180 Buffalo Speedway

City: Houston State: TX ZIP Code: 77005

Phone Number: (713) 490-2225

Accident Information. (If applicable)

Date of Accident: / /

Type of Accident: ☐Work ☐Auto ☐Other

How did the accident happen?

Other Insurance.

Is the patient covered by another insurance plan? ☐Yes ◉No (If yes, please complete the following information.)

Name of Person Carrying Other Insurance (Last, First, MI):

Date of Birth (of person carrying other insurance): / /

Name of Other Insurance Carrier:

Policy Number:

Employer Name:

Effective date of Other Insurance: / /

Cancellation date of Other Insurance (if applicable): / /

Did you attach an EOB from Medicare or your other insurance?: ☐Yes ☐No

Assignment of Benefits.

⊘ Please check this box if you want UnitedHealthcare to pay benefits directly to the doctor/provider.

By signing below, I am stating that the information above is correct. 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.

Signature: _____ Date: 01/01/2019

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