Health Care Expense Claim Form

To be reimbursed for medical claims that you have paid, fill out this entire form and attach copies of any bills, receipts or itemized statements from all providers. For worldwide emergency and urgent care claims, include medical records. Be sure to include your member ID number on all pages of correspondence submitted. If you have questions, call UCare Customer Service at 612-676-3600 or 1-877-523-1515 toll free. TTY users call 651-676-6810 or 1-800-688-2534 toll free.

Note: For pharmacy reimbursement claim forms, please call Customer Service.

Member Information			
Member Name	Date of Birth		
Member ID number	Group number		
Street Address	City	State	Zip
Claim Information			
Check appropriate box below if claim was due to one of the following: □ Auto Accident □ Work-related □ Other Accident			
If you have other insurance, including travel insurance, that may cover all or part of this claim, please provide the insurance company name, address, policy number and group number here.			

Dates of Service		Place of Service Code*	Procedures, Services or Supplies*	Diagnosis Code*	Charges	Physician/Supplier Name, Address, Phone, NPI*	Federal Tax ID*
From	To						
Dates of Service		Place of Service Code*	Procedures, Services or Supplies*	Diagnosis Code*	Charges	Physician/Supplier Name, Address, Phone, NPI*	Federal Tax ID*
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From	To						

*If you don't know where to find some of the requested information, ask your provider for the information needed to complete this form. Add more pages if necessary.

A person who submits an application or files a claim with intent to defraud, or helps commit fraud against an insurer is guilty of a crime.

Authorization: I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give UCare any and all records or information pertaining to medical history or services rendered to me for evaluation of this claim, and for any analytical or research purposes. This authorization will expire one year from the date of signature unless I revoke it sooner.

Member Signature	Date

Please keep copies of all correspondence and send a legible copy of all documents, including this completed claim form to:

UCare
Attn: Claims
PO Box 70
Minneapolis, MN 55440-0070