HealthSelect of Texas

Policy Number: 744260
Customer Service # 1-866-336-9371

Hearing Aid Battery Claim Form SPI 37-6785

UnitedHealthcare®

SAN ANTONIO SERVICE CENTER
PO BOX 740809
ATLANTA , GA 30374-0809

PLEASE SEND HEARING AID BATTERY CLAIM FORM TO SPECIAL ADDRESS LISTED ABOVE

Beginning September 1, 2017, UnitedHealthcare will no longer be the medical plan administrator for the HealthSelect of Texas and Consumer Directed HealthSelect plans. This claim form should be used for claims related to dates for service prior to September 1, 2017. Any claims related to dates of service September 1, 2017 and after should be directed to the current plan administrator.

MEMBER / EMPLOYEE INFORMATION

Subscriber ID:		Phone #: ( )	
Last Name:	First Name:	MI:	Date of Birth / /
Home Address:		New Address? (check box) Yes ☐ No ☐	
City:	State:		Zip Code:

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth / /
Home Address:			
City:	State:		Zip Code:
Sex (circle one): M F	Relationship to Member:		

C. OTHER INSURANCE

Is the patient covered by another insurance plan? (check box) Yes ☐ No ☐ If yes, please complete the following:		
Name of person carrying other insurance:		Date of Birth / /
Social Security #:	Name of Other Insurance Carrier:	
Policy Number:	Employer Name:	

D. DIAGNOSIS AND HCPCS CODES

Diagnosis: Please check one of the following:

	Code	Description
___	H91.90	Unspecified hearing loss, unspecified ear

Please check the item(s) for which you are requesting reimbursement:

Check Box	Date (MM/DD/YYYY)	Place of Service	Code	Description	Total Cost	Quantity(#of batteries)
		OF	V5266	Battery for use in hearing device		

E. PHYSICIAN'S NAME: Pharmacy Tax Identification Number 0-069000008-00001

F. REMINDERS

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 PENALITIES.

- Be sure to include a legible copy of your pharmacy receipt (REQUIRED)
- Clip, do not staple, all receipts to the completed form and mail them to UnitedHealthcare at the address above
- Make sure all bills indicate date of service and cost (refer to Section D above)
- Submit all claims to UnitedHealthcare in a timely manner
- Be sure to notify your employer of all address changes
- Please include your Subscriber Id on all documents