



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) UHC841408548	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Fleming, Amelia		3. PATIENT'S BIRTH DATE MM DD YY 09 06 2007 SEX ☐ M ☐ F	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Fleming, Amelia		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT'S ADDRESS (No., Street)		7. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
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