INSTRUCTIONS TO COMPLETE UNITED CLAIM FORM

PART 1 MEMBER INFORMATION:

"Member" is referred to as the primary policy holder; person responsible for paying insurance. For example, if the Wife is the Patient and she is covered under her Husband's health insurance plan, then the Husband is the Member or primary policy holder.

Patient information Date of Birth and Phone Number
In the same example given above, The Wife would be the Patient and therefore, her date of birth and phone number would go here.

PART 11 SERVICE INFORMATION:

Refer to your office visit receipt to complete this section.

Month/Date/Year	Place of Service	Code for services (CPT)	Diagnosis Code (ICD9)	Charge
Date of Office Visit	Office	Example- 99214	Example- 296.32	Total amount paid

PROVIDER INFORMATION:

Provider Name: Jill Adams NP, LLC **Provider Tax ID:** Located on patient's receipt

Street: 1100 S. Calumet, Suite 2 **City:** Chesterton **State:** IN **Zip Code:** 46304

MAILTO ADDRESS ON CLAIM FORM

See General Instructions at the top of the claim form (attach office visit receipt, etc.)