

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

◆Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

◆If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

◆If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

◆Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident. File claim electronically by clicking [here](#).

◆If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

◆Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

PLANT
DO NOT
HARVEST
OF THIS
AREA

[illegible]

REASSIGNMENT

[illegible]

American Dental Association Dental Claim Form

1. INSURANCE INFORMATION 1. Type of Transaction (New or Renewal) <input type="checkbox"/> New <input type="checkbox"/> Renewal of Actual Policy <input type="checkbox"/> Renewal of Preferred Provider Policy 2. Insurance Contract Number 3. Insurance Underwriter 4. Insurance Company Name Address 1 Address 2 City ST ZIP		INSURANCE COMPANY/CLAIMS INFORMATION 5. Policyholder Name, Address, City, State, Zip Code Policyholder Name Address 1 Address 2 City ST ZIP 13. Date of Birth (MM/DD/YYYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder's Signature (If Not Self)	
2. INSURANCE COVERAGE 6. Other Services or Medical Equipment <input type="checkbox"/> Yes (Specify) <input type="checkbox"/> No (Specify) 7. Amount of Policyholder's Contribution to Premium (If Any) <input type="checkbox"/> Yes (Specify) <input type="checkbox"/> No 8. Date of Last Payment (MM/DD/YYYY) 9. Amount of Last Payment (If Any)		INSURANCE INFORMATION 10. Policyholder's Signature (If Not Self) 11. Signature of Insured (If Not Self) 12. Signature of Agent (If Not Self)	
3. INSURANCE INFORMATION 16. Policyholder's Signature (If Not Self) 17. Signature of Insured (If Not Self) 18. Signature of Agent (If Not Self)		4. INSURANCE INFORMATION 19. Policyholder's Signature (If Not Self) 20. Signature of Insured (If Not Self) 21. Signature of Agent (If Not Self)	
5. INSURANCE INFORMATION 22. Policyholder's Signature (If Not Self) 23. Signature of Insured (If Not Self) 24. Signature of Agent (If Not Self)		6. INSURANCE INFORMATION 25. Policyholder's Signature (If Not Self) 26. Signature of Insured (If Not Self) 27. Signature of Agent (If Not Self)	
7. INSURANCE INFORMATION 28. Policyholder's Signature (If Not Self) 29. Signature of Insured (If Not Self) 30. Signature of Agent (If Not Self)		8. INSURANCE INFORMATION 31. Policyholder's Signature (If Not Self) 32. Signature of Insured (If Not Self) 33. Signature of Agent (If Not Self)	
9. INSURANCE INFORMATION 34. Policyholder's Signature (If Not Self) 35. Signature of Insured (If Not Self) 36. Signature of Agent (If Not Self)		10. INSURANCE INFORMATION 37. Policyholder's Signature (If Not Self) 38. Signature of Insured (If Not Self) 39. Signature of Agent (If Not Self)	
11. INSURANCE INFORMATION 40. Policyholder's Signature (If Not Self) 41. Signature of Insured (If Not Self) 42. Signature of Agent (If Not Self)		12. INSURANCE INFORMATION 43. Policyholder's Signature (If Not Self) 44. Signature of Insured (If Not Self) 45. Signature of Agent (If Not Self)	
13. INSURANCE INFORMATION 46. Policyholder's Signature (If Not Self) 47. Signature of Insured (If Not Self) 48. Signature of Agent (If Not Self)		14. INSURANCE INFORMATION 49. Policyholder's Signature (If Not Self) 50. Signature of Insured (If Not Self) 51. Signature of Agent (If Not Self)	
15. INSURANCE INFORMATION 52. Policyholder's Signature (If Not Self) 53. Signature of Insured (If Not Self) 54. Signature of Agent (If Not Self)		16. INSURANCE INFORMATION 55. Policyholder's Signature (If Not Self) 56. Signature of Insured (If Not Self) 57. Signature of Agent (If Not Self)	
17. INSURANCE INFORMATION 58. Policyholder's Signature (If Not Self) 59. Signature of Insured (If Not Self) 60. Signature of Agent (If Not Self)		18. INSURANCE INFORMATION 61. Policyholder's Signature (If Not Self) 62. Signature of Insured (If Not Self) 63. Signature of Agent (If Not Self)	
19. INSURANCE INFORMATION 64. Policyholder's Signature (If Not Self) 65. Signature of Insured (If Not Self) 66. Signature of Agent (If Not Self)		20. INSURANCE INFORMATION 67. Policyholder's Signature (If Not Self) 68. Signature of Insured (If Not Self) 69. Signature of Agent (If Not Self)	
21. INSURANCE INFORMATION 70. Policyholder's Signature (If Not Self) 71. Signature of Insured (If Not Self) 72. Signature of Agent (If Not Self)		22. INSURANCE INFORMATION 73. Policyholder's Signature (If Not Self) 74. Signature of Insured (If Not Self) 75. Signature of Agent (If Not Self)	
23. INSURANCE INFORMATION 76. Policyholder's Signature (If Not Self) 77. Signature of Insured (If Not Self) 78. Signature of Agent (If Not Self)		24. INSURANCE INFORMATION 79. Policyholder's Signature (If Not Self) 80. Signature of Insured (If Not Self) 81. Signature of Agent (If Not Self)	
25. INSURANCE INFORMATION 82. Policyholder's Signature (If Not Self) 83. Signature of Insured (If Not Self) 84. Signature of Agent (If Not Self)		26. INSURANCE INFORMATION 85. Policyholder's Signature (If Not Self) 86. Signature of Insured (If Not Self) 87. Signature of Agent (If Not Self)	
27. INSURANCE INFORMATION 88. Policyholder's Signature (If Not Self) 89. Signature of Insured (If Not Self) 90. Signature of Agent (If Not Self)		28. INSURANCE INFORMATION 91. Policyholder's Signature (If Not Self) 92. Signature of Insured (If Not Self) 93. Signature of Agent (If Not Self)	
29. INSURANCE INFORMATION 94. Policyholder's Signature (If Not Self) 95. Signature of Insured (If Not Self) 96. Signature of Agent (If Not Self)		30. INSURANCE INFORMATION 97. Policyholder's Signature (If Not Self) 98. Signature of Insured (If Not Self) 99. Signature of Agent (If Not Self)	
31. INSURANCE INFORMATION 100. Policyholder's Signature (If Not Self) 101. Signature of Insured (If Not Self) 102. Signature of Agent (If Not Self)		32. INSURANCE INFORMATION 103. Policyholder's Signature (If Not Self) 104. Signature of Insured (If Not Self) 105. Signature of Agent (If Not Self)	

UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.UHHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 01/29/19
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PEPPER INC

EXPLANATION OF BENEFITS

1	2	3	4	5	6	7	8	
SERVICE DETAIL								
PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DENTIBLE	PLAN BENEFIT COVERED AVAILABLE	REMARK CODE
9001542101	MEDICAL SERVICES	08/10/10	379.00	297.83	81.17		80% 84.94- 44.94	AC
		TOTAL	379.00	297.83				
						MEDICARE PAID PLAN PAID	44.94 20.30	

1-1 INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE".
(4-6)
PLAN CAN DETERMINE BENEFIT. SINCE MEDICARE HAS NO PAYMENT, IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR IN THE LIMITING CHARGE IF THEY DID NOT. ACCORD TO ASSIGNMENT, THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE AMOUNT PAID BY MEDICARE PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND CO-PAYS BEFORE THE PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION	
1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

		320.30
SATISFIED 2010 TO DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY	\$1900.00	\$1228.77
SP	\$600.00	\$1281.45
PLAN YEAR 2010	FAMILY INDIV	FAMILY INDIV
	\$1900.00 \$600.00	\$4302.02 \$4009.00