Re:
Claim #:

Dear,

Please review the claim(s) on the enclosed Explanation of Benefits (EOB). It looks like someone else may be responsible for an illness or injury to the patient listed on the EOB.

We need to know if the patient plans to sue someone or file an insurance claim with anyone who's not UNITE HERE HEALTH.

Because of this, the claim is **DENIED** until the patient gives us this information! If we don't get more information, this claim will remain denied and future related claims may also be denied.

ACTION REQUIRED

We need the enclosed form filled out as soon as possible so we can reconsider this claim and related claims.

You can submit the form by:

a. **Phone:** We'll fill out the form for you! Call the UHH/member number on the back of your medical ID card.

b. **Email:** claims@uhh.org

c. **Mail:** UNITE HERE HEALTH, P.O. Box 6680, Aurora, IL 60598-0020

d. **Fax:** (630) 236-4394

UNITE HERE HEALTH
www.uhh.org

Accident Inquiry Form

Fill out **completely** to prevent delay

We'll fill out this form for you! Call the UHH/member number on the back of your medical ID card.

Or, you can submit the form by:

- **Email:** claims@uhh.org
- **Fax:** (630) 236-4394
- **Mail:** UNITE HERE HEALTH, P. O. Box 6680, Aurora, IL 60598-0020

1: Patient's Claim Information

It looks like someone else may be responsible for your illness or injury. *We need to know if you plan to sue someone or file an insurance claim with anyone who's not UNITE HERE HEALTH.*

Avoid debt collectors!

If you don't check a box to the right, this claim will remain denied and future related claims may also be denied.

Do you plan to sue someone or file an insurance claim with anyone who's not UNITE HERE HEALTH because of this illness or injury?

❑ Yes ❑ No

Was this illness or injury caused by your job duties?

❑ Yes ❑ No

Please describe the illness or injury.

What caused the illness or injury?

When did the illness or injury happen? *(Date/time)*

Where did the illness or injury happen? *(Address/location)*

2: Sign Below

Patient Signature	**Print Name**	**Date**
Member Signature	**Print Name**	**Date**
Member ID/Social Security Number		**Date of Birth**

This information must be submitted to and accepted by UNITE HERE HEALTH within 12 months from the date you received the denial of related benefits.