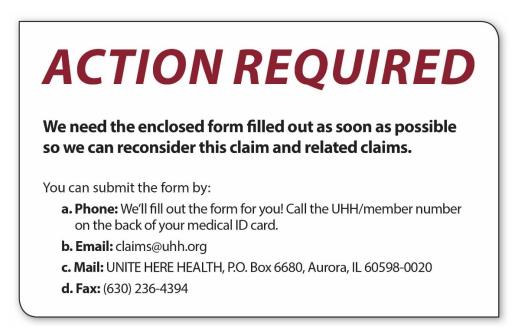
Re: Claim #:

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.



WWW.uhh.org	Accide	nt Inquiry Form
Fill out <b>completely</b> 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 6	
1: Patient's Claim Information		
It looks like someone else may be responsible for your illness or injury. <i>We need to know if you plan</i> to sue someone or file an insurance claim with anyone who's not UNITE HERE HEALTH.		
Avoid deb collectors		or file an insurance claim with anyone H because of this illness or injury?
If you don't check a box to the right, this claim will remain denied and future related claims may also be denied.		s 🗆 No
	Was this illness or injury cause	ed by your job duties?
	/ 🗆 Yes	5 🗆 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) <b>•</b>		
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.		