



Claim Status Request

Date of Service: _____

\$\$ Amount: _____

Reply To Request (For Univera Healthcare's Use Only)

The claim specified above was:

- Paid on: _____
Check Number: _____
- Denied on: _____
Reason for denial _____

- No record. Please resubmit.
- Claim in process.
- Claim will be released in next pay run.

Mail or fax the completed form to:

Univera Healthcare
PO Box 211256
Eagan, MN 55121

Fax:
1-877-203-9401

Phone:
1-866-265-5983

Fax:
1-888-273-8296

Phone:
1-888-638-7149

Today's Date:

*Member Plan
(select one)::*

- Univera Healthcare
- SeniorChoice
- Univera PPO
- Medicare PPO
- ASO
- Other:

Provider Name: _____

Provider ID Number: _____

Contact: _____

Phone: _____

Fax: _____

Member ID Number: _____

Member Name: _____