Genetic Material Storage and Transportation Claim Form for California Members

Use this form if you have been billed directly by a provider/vendor for genetic material storage or transportation services and are requesting reimbursement. If your provider/vendor submits the claim directly to UnitedHealthcare, you do not need to submit this form. Complete Sections A and B. Ask the provider/vendor to complete Section C for the applicable storage or transportation service. Submit the completed form and an itemized receipt or invoice to the address on the back of your UnitedHealthcare ID card. **Submission of this form does not guarantee reimbursement. Coverage and reimbursement are determined in accordance with your applicable benefits and claims requirements.**

GUIDELINES FOR SUBMITTING GENETIC MATERIAL STORAGE CLAIM FORM TO UNITEDHEALTHCARE

- This form is for California members who have been billed directly by a provider/vendor for genetic material storage or transportation services and are requesting reimbursement.
- MAIL the Claim Form and the itemized receipt/invoice for the storage or transportation services from your provider/vendor to the address on the back of your ID card.
- **Please ensure Section C is completed by the provider/vendor with the correct date of service, the provider tax identification number and the California Tissue Bank License Number, if applicable.**
- If you have paid the provider/vendor directly, please submit this form and the requested documentation and UnitedHealthcare will review your request for reimbursement in accordance with your applicable benefits and claims requirements.
- Submit the claim form to UnitedHealthcare in a timely manner.
- Be sure to notify your employer of all address changes.
- Please include your UnitedHealthcare Member Number and Date of Birth on any attachments and receipts/invoices.

A. SUBSCRIBER INFORMATION: Employee Complete this Section

Last Name:	First Name:	MI:	Date of Birth: / /
SSN or Member ID Number on UnitedHealthcare ID Card:	Policy Number:	Phone: ( )	
Home Address:			New Address: Yes ☐ No ☐
City:	State:		Zip Code:

B. PATIENT INFORMATION: Employee Complete this Section

Last Name:	First Name:	MI:	Date of Birth: / /
SSN or Member ID Number on UnitedHealthcare ID Card:	Policy Number:	Phone: ( )	
Home Address:			New Address: Yes ☐ No ☐
City:	State:		Zip Code:

C. PROVIDER: Provider Complete this Section and Line for the Applicable Service

Date of Service	Place of Service	Procedure Code	Diagnosis Code	Unit (Indicates One Year)	CHARGES
	11	89342 Storage (per year); embryo(s)	Z31.84	1	
	11	89343 Storage (per year); sperm/semen	Z31.84	1	
	11	89346 Storage (per year); oocyte(s)	Z31.84	1	
		Transportation of genetic material			
☐ **Is this claim related to Iatrogenic Infertility?** "Iatrogenic infertility" means being unable to have children because of surgery, chemotherapy, radiation, gender-affirming care or another medical treatment. **Original Cryopreservation Date:**				**TOTAL CHARGE(S)**:	

Provider's/Vendor's Name: Provider's Tax ID Number or Social Security Number:
Provider's/Vendor's CA Tissue Bank License Number (if applicable):
Provider's Address:
Provider's Telephone Number: ( )
Provider's Signature: _____ Date:_____

D. MEMBER SIGNATURE:

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Member Signature: _____ Date: _____