



Claim Status Request

Today's Date: _____

Provider Name: _____

Provider ID#: _____

Contact: _____

Phone: _____ Fax: _____

Member ID Number: _____

Member Name: _____

Plan (*Select one*):

Univera Healthcare SeniorChoice Univera PPO Medicare PPO

PlusMed Child Health Plus Family Health Plus ASO

Other: _____

Date of Service: _____

\$\$ Amount: _____

Mail or fax the completed form to:

Univera Healthcare
Provider Service
205 Park Club Lane
Buffalo, NY 14221-5239

Fax:
(716) 857-4610
1 (800) 742-6153

Phone:
(716) 857-4444
1 (800) 617-1114

Univera Community Health
P.O. Box 66
Pittsford, NY 14534

Fax:
1 (888) 273-8296

Phone:
1 (888) 638-7149

Reply To Request (For Univera 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.