UnitedHealthcare®
Oxford

Deductible Credit Form
Prior Deductible

Employee name: _____

Employer name: _____

Member ID # or Social Security #: _____

Please fill in the information below for yourself and, if applicable, each of your covered dependent family members for whom you are applying for a deductible credit. Be sure to include an Explanation of Benefits (EOB) from your prior group health plan showing the portion of the deductible amount that you have met to date, as well as the portion of the deductible amount any covered dependent family member has met to date (individual deductibles).

To help ensure the timely processing of this request, you should also fill in on the "Amount Satisfied" line below, the portion of the deductible amount that you and your family members have met to date. Indicate the amount for each person listed on the form.

Employee's name: _____ ID #: _____

Amount satisfied: _____

Spouse's name: _____ ID #: _____

Amount satisfied: _____

Dependent's name: _____ ID #: _____

Amount satisfied: _____

Dependent's name: _____ ID #: _____

Amount satisfied: _____

Dependent's name: _____ ID #: _____

Amount satisfied: _____

Dependent's name: _____ ID #: _____

Amount satisfied: _____

Please submit the enclosed form along with supporting documentation (i.e., EOB) to:

Deductible Credit Center
P.O. Box 29135
Hot Springs, AR 71903

19-13660 9/19

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