



Staple itemized statement or receipt here to the back of this form

Member Claim Submission Form

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to item #6 on the back of this form for the items required for claim submission. If sufficient documentation is not received, claim will not be processed.

Name of Employer:				Plan Group Nur	mber:
Name of Employee:				Member ID:	
Patient's Name:				Date of Birth:	
Employee Phone Number and/or Email Address					
Issue Payment to:	Member	Provider			
			Provid	der Tax ID #	
Provider Name:					(USA only) (Required field – please contact your
Provider Address:					provider if statement is missing this info)
Type of Service	Check all that apply. PLEASE NOTE - ALL	. SERVICE TYPE	S MAY NOT BE CO	OVERED UNDE	ER YOUR PLAN.
Vision	Exam	Frame	Lenses	Contacts	Other (complete below)
Medical	Office Visit		Flu Shot		Breast Pump
	Lab		Immunization		Durable medical equipment
	X-Ray		Prescription		Other (complete below)
If you checked Other, please complete the information below:					
Please use this space to briefly describe services rendered					
Example - UV Coating, Wellness/Gym Membership, Acupuncture, Foreign claims (ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.)					

Email a pdf of your claim and documents to:

UMR-ClaimSubmission@UMR.COM

See back of form for complete claim filing instructions

You may submit your claim to UMR by one of the following methods: Mail:

FAX: 855-405-2189

UMR

PO Box 30541

Salt Lake City, UT 84130-0541

Filing your claim is easy. Please review these important tips.

- 1 Use this form to file a claim for any eligible medical expense when your physician or other provider does not file a claim. Please print clearly with black ink completing all required fields.
- 2 Attach your itemized statement (or fully legible copy of the bill) to the back of this form. Keep a copy for your records.

Please use a separate claim form for each health care professional and for each family member.

- 3 See your UMR ID card for:
 - *Name of Employer
 - *Plan Group Number
 - *Name of Member (as it appear on the ID card)
- 4 Patient name and date of birth must match UMR's eligibility file.

 Example if your name was Eugene Smith on your enrollment form, claim must state Eugene, not Gene
- 5 Name, address and Tax ID number of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the receipt, you can contact their office to obtain it.
- 6 To be considered a valid claim, (with the exception of gym memberships) your bill should include the following information:
 - -Patient name
 - -Date of service
 - -Description of service (i.e.: office visit, injection, immunization, glasses)
 - -Diagnosis (type of illness or injury)
 - -A charge of each service
 - -Name, address and Tax ID number of the provider (required field for services rendered in the US or US territories)
- 7 If your plan covers gym memberships or other services not considered traditional medical expenses, the information needed to file a claim can vary. Date of service and diagnosis may not apply.
- 8 Balance Due Statements are not valid claims. See above for information needed to constitute a valid claim.
- 9 Your submission will be scanned. Staple any attachments to the back of the claim form, not the front. Additionally, please indicate the member number on any attachments, should paperwork be separated from the claim form.
- 10 Claim address listed on the bottom of the claim form is for member use only; providers should bill to the address on the member ID card. This fax number also supports international faxing.
- 11 Only Prescriptions/drug charges that are allowable under your UMR medical plan should be submitted on this form