EZ Claim Form Medical/Vision

Name of Employer: _____ **Group #:** _____

Name of Employee: _____ **Member ID#:** _____

Patient's Name: _____ **Date of Birth:** ____/____/____
(Last Name, First, Middle Initial)

Is claim related to an accident: ☐No ☐ Yes
If yes, provide details including date, description and location of accident

_____

Is patient covered by another group plan? ☐No ☐ Yes

If yes, type of other coverage: ☐Medical ☐ Dental ☐ Vision

Carrier: _____

Group Number: _____ Employee Name: _____

ID Number: _____ Name of Employer: _____

Please attach your prescription receipts and physician's statement.

THE FOLLOWING INFORMATION MUST BE ON YOUR RECEIPT OR ON YOUR PROVIDER INVOICE AND SUBMITTED WITH THIS CLAIM FORM IN ORDER TO PROCESS YOUR CLAIM (PLEASE CHECK EACH BOX):
Cash register receipts or cancelled checks are not an acceptable claim.

☐ Date of Service
☐ CPT (procedure) Code
☐ Provider Name
☐ Diagnosis Code
☐ Provider Tax Identification Number (TIN)
☐ Billed Charges and Amount Paid

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For prescription claims please provide a copy of the drug receipt, outlining name of the pharmacy, drug, Rx number and date purchased.

Issue Payment to: ☐Provider or ☐Employee

_____ _____
(Employee's Signature) (Date)

As a member you may submit your claim to UMR by one of the following methods:

Fax claims to:
855-444-2896

Mail the claims to:
UMR
PO Box 35041
Salt Lake City, UT 84130-0541

Email a .pdf of your claim to:
umr-claimsubmission@umr.com