HEALTH CLAIM FORM

PATIENT INFORMATION

1. EMPLOYEE'S SSN	GROUP NUMBER 220701	GROUP NAME
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTHDATE (mm/dd/yr) | | SEX M F	4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO EMPLOYEE Self Spouse Child Other	7. EMPLOYEE'S ADDRESS (No. Street)
CITY / STATE	8. PATIENT STATUS Single Married Other Employed Full-time Student Part-time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	11. EMPLOYEE'S POLICY GROUP
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? YES NO PLACE (State) [_______]	a. EMPLOYEE'S DATE OF BIRTH (mm/dd/yr) | | SEX M F
b. OTHER INSURED'S DATE OF BIRTH (mm/dd/yr) | SEX M F	c. OTHER ACCIDENT? YES NO d. PLEASE PROVIDE ACCIDENT DETALS:	b. CLAIMS ADMINISTRATOR **UMR** PO Box 2876 Clinton, IA 52733-2876 (866) 868-1223 e-mail address: service@umr.com or www.umr.com
c. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED____________________ DATE____________

13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (mm/dd/yr) | |	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (mm/dd/yr) | |	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (mm/dd/yr) TO (mm/dd/yr)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	18. I.D. NUMBER OF REFERRING PHYSICIAN	19. HOSPITAL DATES RELATED TO CURRENT SERVICES FROM (mm/dd/yr) TO (mm/dd/yr)	20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. |________.____
2. |________.____
3. |________.____
4. |________.____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23, PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From (mm/dd/yr)	To(mm/dd/yr)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSOT Family Plan	I EMG	J COB
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE

31, SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN/SUPPLIER BILLING ADDRESS: PIN# | GRP#