

Health Claim Form

Employees:

- Please complete items 1 through 8 in full.
- Please complete items 9 through 11 only if you have other medical coverage, including Medicare.
- Please be sure to sign the authorization so we can release information on items 12 and 13 if necessary.
- If you have submitted a request for benefits under another health plan (including Medicare), please attach a copy of the bills you sent to the other plan and the Explanation of Benefits form the plan sent to you.

5. Attach itemized bills or ask your health care provider to complete the applicable section. The bills must include:

- Patient's name
- Date(s) of service
- Condition being treated
- Relationship to employee
- Type of service(s) given

If any of this information is missing, simply write it on the bill and sign your name.

- Keep copies of your bills for your records.
- The mailing address for claims is on the back of your ID card.



Employee Information

1. Employee's SSN		8. Patient Status		11. Employee's Policy/Group No.	
		Single	Married	220701	
Group Number		Employed?	Yes	a. Employee's Date of Birth	
220701		Full Time Student?	No		
Group Name		Part Time Student?	Yes	b. Claims Administrator	
Public Employees' Benefits Program (PEBP)			No	UMR	
2. Patient's Name (Last, First, Middle Initial)		9. Other Insured's Name (Last, First, Middle Initial)		PO Box 2876	
		a. Other Insured's Policy or Group No.		Clinton, IA 52733-2876	
3. Patient Birthdate		b. Other Insured's Date of Birth		email: service@umr.com	
	Gender	Gender		www.umr.com	
	M F	M F		c. Is there another Health Benefit Plan? (additional coverage)	
4. Employee's Name (Last, First, Middle Initial)		c. Employer's Name or School Name		Yes No	
		d. Insurance Plan Name or Program Name		(If Yes, return to and complete item 9 a-d)	
5. Patient's Address		10. Is Patient's Condition Related to:		12. Patient's or Authorized Person's Signature	
Street		a. Employment? (Current or Previous)		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.	
City		Yes No		Signed	
State		b. Auto Accident?		Date	
6. Patient's Relationship to Employee		Yes No		13. Authorized Person's Signature	
Self Spouse Child Other		c. Other Accident?		I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
7. Employee's Address		Yes No		Signed	
Street		d. Please provide accident details:		Date	
City					
State					

Physician and supplier form on reverse side...

Physician or Supplier Information

14. Date of Current Illness (First Symptoms) or Injury (Accident) or Pregnancy (LMP)		17. Name of Referring Physician or Other Source		21. Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	
				1	
15. If Patient has had Same or Similar Illness Give First Date		18. I.D. No. of Referring Physician		2	
				3	
16. Dates Patient Unable to Work in Current Condition		19. Hospital Dates Related to Current Services		4	
From:	To:	From:	To:	22. Medicaid Resubmission	
				Code:	Original Ref. No.
20. Outside Lab? \$ Charges				23. Prior Authorization Number	
Yes	No				

24.	A		B	C	D		E	F	G	H	I	J
	To	From	Place of Service	Type of Service	Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT HCPCS Modifier	Diagnosis Code	Charges	Days or Units	EPSOT Fam Plan	EMG	COB	
1												
2												
3												
4												
5												
6												

25.		32. Name and Address of Facility Where Services were Rendered	
Fed. Tax ID Number		Name	
SSN		Street	
EIN		City	
26. Patient Account Number		State	
		33. Physician/Supplier Billing Address:	
27. Accept Assignment?		Street	
Yes	No	City	
28. Total Charge		State	
		PIN#	GRP#
29. Amount Paid			
		31. Signature of Physician or Supplier	
30. Balance Due		Signed	
		Date	

Physician or Supplier:

- Complete items 14 through 33 in full
- If the employee indicates benefits should be paid directly to you, then these benefits will be sent directly to you and an informational copy of the transaction will be sent to the employee.

