RETURN TO: UMR
PO BOX 30541
Salt Lake City, UT 84130-0541

▲ THIS AREA IS FOR UMR OFFICE USE ONLY ▲

Medical Claim Form
—Instructions on Reverse—

TO BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME *(First name, middle initial, last name)*

4. EMPLOYEE'S ADDRESS *(Street, City, ZIP code, Phone Number)*
☐ *Check Box if this is a change of address*
TELEPHONE NUMBER: ( )

5. PATIENT'S SEX
MALE ☐ ☐ FEMALE

6. MEMBER ID NUMBER

7. PATIENT'S RELATIONSHIP TO EMPLOYEE
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. Nature of Illness/Injury: Provide Date of Injury: How/Where it Occured

9. OTHER GROUP HEALTH COVERAGE YES ☐ ☐ NO
ENTER NAME OF COVERED INDIVIDUAL, PLAN NAME, ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER:

10. WAS CONDITION RELATED TO
A. Patient's Employment Yes ☐ ☐ No
B. An Auto Accident* Yes ☐ ☐ No
C. Other Accident/Injury* Yes ☐ ☐ No
***PLEASE ATTACH ACCIDENT REPORT**

11. SPOUSE'S EMPLOYER'S NAME AND ADDRESS *(Street, City, State, ZIP Code)*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical information necessary to process this claim.
SIGNED *DATE*

13. I AUTHORIZE PAYMENT TO UNDERSIGNED DOCTOR OR SUPPLIER
SIGNED *DATE*

TO BE COMPLETED BY DOCTOR OR SUPPLIER

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING DOCTOR OR OTHER SOURCE (e.g. public health agency)
Provider Number

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED (if other than home or office)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC or DX CODE.
1.
2.
3.
4.
CODES

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — Procedure Code (Identify)	(Explain Unusual Services Or Circumstances	D Diagnosis Treated Code	E CHARGES

25. SIGNATURE OF DOCTOR OR SUPPLIER
SIGNED *DATE*

26. DOES DOCTOR ACCEPT ASSIGNMENT FOR MEDICARE?
YES ☐ ☐ NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

31. DOCTOR'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

32.

33. YOUR EMPLOYER TAX I.D. NO.

PROVIDER NUMBER

UMR MEDICAL CLAIM FORM
WITH STUDENT STATUS KYMEDB (5/98)

MCF - GEN 3/99