UMR

CLAIM SUBMISSION FORM

Please complete this form and send it, along with the detailed bill from your health care provider, to the address or fax number provided below. *PLEASE PRINT*.

GROUP INFORMATION

Group/Employer Name: _____

Group # (printed on employee ID card): _____

EMPLOYEE INFORMATION

Employee Full Name: _____

Employee Address: _____
Street Address

_____
City *State* *ZIP Code*

Please check box if this is a new address: ☐

Employee Phone #: (____) - _____ - _____

Employee Date of Birth: _____ / _____ / _____

Employee Social Security #: _____ - _____ - _____
OR …
Employee Participant # (printed on employee ID card): _____

PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____ / _____ / _____

_____ _____ / _____ / _____
Employee Signature *Date*

PLEASE NOTE: We cannot process a claim from a "balance due" statement. Please send this completed claim form, along with the detailed bill from your health care provider, to …

By mail…
UMR
2700 MIDWEST DRIVE
ONALASKA WI 54650

Or by fax:
608.783.8850

Questions? Please call the customer service number on the back of your ID card. Thank you.