

## **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 INFORM	MATION			
Employee Full Name:				
Employee Address:				
	Street Address			
	City	State	ZIP Code	
Please check box if this i	s a new address: [	]		
Employee Phone #: (	)			
Employee Date of Birth	://_			
Employee Social Secur <i>OR</i> Employee Participant #				
PATIENT INFORMA	TION			
Patient Full Name:				
Patient Date of Birth: _	//			
			///	
Employee Signature			Date	
			ment. Please send this complete	d
claim form, along with the o By mail UMR 2700 MIDWEST D ONALASKA WI 5	RIVE	n nealth care provider, to	Or by fax: 608.783.8850	

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