| Staple itemized statement or receipt here to the back of this form | **Member Claim Submission Form** | **UMR** |

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to item #6 on the back of this form for the items required for claim submission. **If sufficient documentation is not received, claim will not be processed.**

Name of Employer: _____   Plan Group Number: _____

Name of Employee: _____   Member ID: _____

Patient's Name: _____   Date of Birth: _____

Employee Phone Number and/or Email Address: _____

Issue Payment to: ☐ Member   ☐ Provider

Provider Name: _____

Provider Address: _____

Provider Tax ID #
9 Digits:
(USA only) _____

(required field - please contact your provider if statement is missing this information)

Type of Service	Check all that apply. **NOTE - ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.**				**PLEASE**
☐ Vision	☐ Exam	☐ Frame	☐ Lenses	☐ Contacts	☐ Other (complete below)
☐ Medical	☐ Office Visit	☐ Flu Shot			☐ Breast Pump
	☐ Lab	☐ Immunization			☐ Durable medical equipment
	☐ X-Ray	☐ Prescription			☐ Other (complete below)

If you checked Other, please complete the information below:

Please use this space to briefly describe services rendered
Example - UV Coating, Wellness/Gym Membership, Acupuncture, Foreign claims (ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.)

You may submit your claim to UMR by one of the following methods:

FAX: 855-405-2189

Mail:
UMR
PO Box 8033
Wausau WI 54402-8033

Email a pdf of your claim and documents to:
UMR-ClaimSubmission@UMR.COM

See back of form for complete claim filing instructions