



EZ Claim Form Medical/Vision

Name of Employer: _____ Group #: _____

Name of Employee: _____ Member ID#: _____

Patient's Name: _____ Date of Birth: ____/____/____
(Last Name, First, Middle Initial)

Is claim related to an accident: [] No [] Yes
If yes, provide details including date, description and location of accident

Is patient covered by another group plan? [] No [] Yes

If yes, type of other coverage: [] Medical [] Dental [] Vision

Carrier: _____

Group Number: _____ Employee Name: _____

ID Number: _____ Name of Employer: _____

Please attach your prescription receipts and physician's statement.

THE FOLLOWING INFORMATION MUST BE ON YOUR RECEIPT OR ON YOUR PROVIDER INVOICE AND SUBMITTED WITH THIS CLAIM FORM IN ORDER TO PROCESS YOUR CLAIM (PLEASE CHECK EACH BOX):

Cash register receipts or cancelled checks are not an acceptable claim.

- [] Date of Service [] Diagnosis Code
[] CPT (procedure) Code [] Provider Tax Identification Number (TIN)
[] Provider Name [] Billed Charges and Amount Paid

For prescription claims please provide a copy of the drug receipt, outlining name of the pharmacy, drug, Rx number and date purchased.

Issue Payment to: [] Provider or [] Employee

_____(Employee's Signature) _____(Date)

As a member you may submit your claim to UMR by one of the following methods:

Fax: 855-444-2896

Mail: UMR
PO Box 30787
Salt Lake City, UT 84130-0787