# 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
☐ CPT (procedure) Code
☐ Provider Name
☐ Diagnosis Code
☐ Provider Tax Identification Number (TIN)
☐ Billed Charges and Amount Paid

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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 claims to:
**855-444-2896**

Mail the claims to:
**UMR**
**PO Box 30541**
**Salt Lake City, UT 84130-0541**

Email a .pdf of your claim to:
**umr-claimsubmission@umr.com**