



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)

UMR logo and address information

855-444-2896

UMR
PO Box 30541
Salt Lake City, UT 84130-0541

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