Please mail claims to:
UMR -0704
P.O. Box 2838, Clinton, IA 52733-2838
Fax: 866-899-0291

MEDICAL CLAIM FORM

1 – MEMBER/PATIENT

Employee's name (First, Middle, Last)	Employee's Social Security # / Alt ID	Group #
		240104

Present Address – Street	City	State Zip Code	Phone Number
			( )

Patient's name (First, Middle, Last)	Patient's relationship to Employee	Sex	Birth Date
	❑ Self ❑ Spouse ❑ Child ❑ Handicapped dependent	❑ M ❑ F	/ /

2 – OTHER INSURANCE

DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ❑ YES ❑ NO IF YES, COMPLETE SECTION 2.

Policyholder's name (First, Middle, Last)	Birth Date	Policyholder's employment status
	/ /	❑ Active ❑ Disabled ❑ COBRA ❑ Retired ❑ Effective date: / /

Policyholder's relationship to member	Other insurance carrier's name	Identification #	Effective Date
❑ Self ❑ Spouse ❑ Child ❑ Other			/ /

Type(s) of coverage (Check all that apply) ❑ Hospitalization ❑ Medical-surgery ❑ Dental ❑ Drug ❑ Major medical ❑ Other (specify): _____

Contract covers: ❑ Policyholder only ❑ Policyholder and Spouse ❑ Policyholder and Child(ren) ❑ Family

Is the **patient** entitled to benefits under **Medicare** Part A or B? ❑ YES ❑ NO If YES, complete the rest of Section 2.

Medicare effective date / / Medicare ID # _____

Member's employment status ❑ Active ❑ Retired ❑ Disabled

3 – PATIENT'S CONDITION

a. This claim is for the following service: ❑ Medical

b. **Attach physician statement (receipt or bill) which includes the diagnosis code, procedure codes, dates of service, place of service, charges, and physicians/supplier tax ID number and signature.**

c. Was this claim the result of an accident or injury? ❑ YES ❑ NO If yes, complete Questions 3d and 3e.

d. Accident or injury date / / ❑ Work ❑ Auto ❑ School ❑ Other (Specify) _____

e. Do you intend to file a claim against another individual, business, organization, or insurer for medical expenses arising from the accident or injury? ❑ YES ❑ NO Have you retained an attorney? ❑ YES ❑ NO

f. Were the services related to an inpatient hospitalization stay? ❑ YES ❑ NO If YES, complete the rest of Question 3f.

Admission date / / Discharge date / /
Hospital name _____ Admitting Physician _____

4 - AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any Insurance Company, Prepayment Organization, Employer, Hospital, or Physician to release all information with respect to me or my dependents that may have a bearing on the benefits under this or any other plan providing benefits or services.

SIGNED (PATIENT, OR PARENT IF A MINOR)

➤ **DATE**

5 – DIRECTION OF PAYMENT

NOTICE – Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered a felony in some states.

REIMBURSEMENT TO BE PAID TO (CHECK ONE) **❑ PLAN MEMBER ❑ PROVIDER OF SERVICE**

SIGNATURE REQUIRED (INSURED PERSON)

➤ **DATE**