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RETURN TO: United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

Medical Claim Form
—Instructions on Reverse—

(IF CLAIM IS FOR A FULL TIME STUDENT OVER AGE 19 ATTACH CURRENT SCHOOL SCHEDULE)

TO BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME (First name, middle initial, last name)	
4. EMPLOYEE'S ADDRESS (Street, City, ZIP code, Phone Number) <input type="checkbox"/> Check Box if this is a change of address		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. MEMBER ID NUMBER	
TELEPHONE NUMBER: ()		7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. Nature of Illness/Injury: Provide Date of Injury: How/Where it Occurred	
9. OTHER GROUP HEALTH COVERAGE ENTER NAME OF COVERED INDIVIDUAL, PLAN NAME, ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER: YES <input type="checkbox"/> NO <input type="checkbox"/>		10. WAS CONDITION RELATED TO A. Patient's Employment Yes <input type="checkbox"/> No <input type="checkbox"/> B. An Auto Accident* Yes <input type="checkbox"/> No <input type="checkbox"/> C. Other Accident/Injury* Yes <input type="checkbox"/> No <input type="checkbox"/>		11. SPOUSE'S EMPLOYER'S NAME AND ADDRESS (Street, City, State, ZIP Code)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>I authorize the release of any medical information necessary to process this claim.</i>		13. I AUTHORIZE PAYMENT TO UNDERSIGNED DOCTOR OR SUPPLIER			
SIGNED _____ DATE _____		SIGNED _____ DATE _____			

TO BE COMPLETED BY DOCTOR OR SUPPLIER

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING DOCTOR OR OTHER SOURCE (e.g. public health agency) Provider Number _____				20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICE RENDERED (if other than home or office)				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1 2 3 ETC or DX CODE.

1. _____	CODES _____
2. _____	_____
3. _____	_____
4. _____	_____

A DATE OF SERVICE		B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D Diagnosis Treated Code	E
FROM	TO		Procedure Code (Identify)	(Explain Unusual Services Or Circumstances)		CHARGES

25. SIGNATURE OF DOCTOR OR SUPPLIER		26. DOES DOCTOR ACCEPT ASSIGNMENT FOR MEDICARE? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE	
SIGNED _____ DATE _____		31. DOCTOR'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.							
32. _____		33. YOUR EMPLOYER TAX I.D. NO.		PROVIDER NUMBER _____					

FILING FOR PAYMENT OF DOCTOR'S SERVICES

Complete top portion of the Medical Expense Claim Form and have your doctor complete the remainder of the form. OR,

Complete top portion of the Medical Expense Claim Form and attach itemized statement(s) from your doctor.

FILING FOR PAYMENT OF OTHER HEALTH CARE SERVICES

Complete top portion of the Medical Expense Claim Form and attach itemized statement from the supplier.

To assure that you will be paid without delay, make sure that this form is completed correctly.

1. Did you print your member ID number in block 6?
2. If the answer in block 9 is "yes" did you include the name, address and policy number of your other coverage?
3. If any question in block 10 is answered "yes", did your doctor complete block 14?
4. Did you sign the form in block 12?
5. Did you sign the form on line 13 if you wish for the doctor or supplier to be paid directly?
6. Did you make a copy of this form and your receipts for your records?

IF YOU ARE ATTACHING AN ITEMIZED STATEMENT, PLEASE CHECK TO SEE THAT EVERY ITEMIZED RECEIPT OR BILL SHOWS THE FOLLOWING:

1. Patient's name.
2. Type of treatment.
3. Date and charge of each office visit, surgical procedure, x-ray examination, laboratory examination and shots, etc.
4. Diagnosis or nature of illness.

Send Claims to:

UMR
P.O. BOX 145804
CINCINNATI, OHIO 45250-5804

For Questions:

Contact UMR at 1-800-950-4867