YOUNG LIFE BENEFITS PLAN

UMR Medical Claim Form

Employer Name: Young Life

Group #: 76-410569

Employee Name: _____

Member ID#: _____

Patient Name: _____

Patient Date of Birth: _____/_____/_____

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 Name: _____

Group #: _____

Employee Name: _____

ID #: _____

Employer Name: _____

Please include your healthcare provider's invoice/statement along with this claim form to ensure proper handling by UMR. Cash register receipts and cancelled checks are not acceptable claims.

PLEASE CHECK OFF EACH ITEM BELOW TO VERIFY THAT THE PROVIDER INVOICE CONTAINS THE REQUIRED INFORMATION (Not required for breast pump invoices.) PLEASE INDICATE WHO SHOULD RECEIVE THE REIMBURSEMENT.

_____Date of Service

_____Diagnosis Code or Description of Service

_____Procedure Code or Description of service

_____Provider Tax Identification Number (TIN)

_____Provider Name and Address

_____Billed Charges and Amount Paid

Issue Payment to: _____Provider or _____Employee

Payment will be made via check unless you have enrolled in the direct deposit option on the UMR website.

Employee Signature: (print or electronic)

Date:

Submit your claims directly to UMR:

Fax Claims to:
877.291.4373

OR

E-mail a PDF of your claims to:
umr-younglife@umr.com
(preferred method)