

YOUNG LIFE BENEFITS PLAN

International Medical/Rx Claim Form

Please fax or e-mail this form to UMR and include all related receipts: (877) 293-4926; umr-younglife@umr.com

Please submit a separate form for each family member and list each service date individually below.

**** Claims MUST be submitted within 12 months of the service date, or they will be denied ****

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Employee Name: **Last 4 SS#: xxx-xx-**

Patient Name: **Patient Date of Birth:**

Group # 76-410569 **Medical Card ID#:**

Payment Authorization

I elect to receive reimbursement by Direct Deposit and hereby authorize UMR to initiate deposits to the bank account number I have provided below. This feature will carry over from year to year unless revoked in writing.

Account # **Routing #**

E-Signature **Today's Date**

Please verify the account and routing numbers as your payment will be delayed if they are incorrect.

If any service is treatment for a non-work-related accident or injury, designate with an asterisk (*) and provide the date of injury and accident details:

If any service **is** for a work-related accident or injury, please complete forms [#1744](#) and [#1850](#) and fax or e-mail them and accompanying receipts to Irene Outlar in the YL Insurance Department: (719) 867-3581; ioutlar@sc.younglife.org. ☐

For consistency, please access [Oanda](#) for the exchange rate and use the paid date of your services. ☐

Claim # *	Service Date	Paid Date	Type of Service (Office visit, lab, RX, hospital, ER, etc.)	Local Currency	U.S. Dollars	Medical Condition (Flu, back pain, high blood pressure, broken arm, etc.)
Totals						

* Claim numbers are assigned by you and used for reference. The numbers on this form should match the numbers on the actual receipts.

YL-1755 (Jan. 2019)

