



YOUNG LIFE BENEFITS PLAN

UMR Hawaii 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 ____ in order to receive the accident benefit.

Other Coverage

Patient is covered by HMSA for most services incurred in Hawaii with the exception of chiropractic and massage therapy. UMR is primary on these services and any services incurred in the U.S.

PLEASE ASK THE PROVIDER FOR AN ITEMIZED INSURANCE BILLING OR A SUPER BILL. Cash register receipts or cancelled checks are not acceptable claims.

THE FOLLOWING INFORMATION MUST BE ON THE PROVIDER INVOICE AND SUBMITTED WITH THIS FORM IN ORDER TO PROCESS YOUR CLAIM.

- Date of Service
- Diagnosis Code or Description
- Procedure Code or Description
- Provider Tax Identification Number (TIN)
- Provider Name
- Billed Charges and Amount Paid

Issue Payment to Employee

(Payment will be made via check unless you have a direct deposit record on file. You may enroll from the UMR home page, www.umar.com, as well as update your profile to receive electronic claim notices.)

Employee Signature: (print or electronic)

Date:

Submit your claim(s) to UMR by one of the following methods (email provides the quickest turn-around time):

Fax Claims to:
877.291.4373

Mail claims to:
UMR, PO Box 30541
Salt Lake City, UT 84130-0541

Email a PDF of your claims to:
umar-younglife@umar.com
(preferred method)