



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)