# UMR MEMBER CLAIM REIMBURSEMENT FORM


Larimer County Employee Benefit Plan
200 West Oak Street, Suite 3200
Ft. Collins, Colorado 80521

**To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information listed below.**

**Submit claims to:** **UMR - Attn: Larimer County Team**
**20021 - 120th Ave, 2nd Fl, Ste 200**
**Bothell WA 98011 / Fax: 866-859-1112**
**Email: LCReimbursementClaim@umr.com**

## EMPLOYEE INFORMATION

| EMPLOYER | | | GROUP NUMBER |
|---|---|---|---|
| **LARIMER COUNTY / DEPT:** | | | **76-411073** |
| EMPLOYEE - LAST, FIRST, MI | | | **MEDICAL ID NUMBER WITH UMR** |
| STREET ADDRESS | CITY | STATE | |
| ZIP | DATE OF BIRTH | PHONE NUMBER | EMAIL |

## PATIENT INFORMATION (if other than employee)

| LAST NAME, FIRST, MI | RELATIONSHIP TO EMPLOYEE: |
|---|---|

## PROVIDER INFORMATION

| PROVIDER NAME: | PROVIDER TAX ID (9 digits): |
|---|---|
| PROVIDER PHONE NUMBER: | **(USA only: required field-please contact provider if statement or receipt is missing information.)** |

## TYPE OF SERVICE (check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | VISION EXAM | DO YOU HAVE VSP COVERAGE? IF SO, ATTACH VSP EXPLANATION OF BENEFITS | | | | | |
| | MEDICAL | | OFFICE VISIT | | FLU SHOT | | ACUPUNCTURE |
| | | | LAB / X-RAY | | IMMUNIZATION | | MASSAGE |
| | | | OTHER: briefly describe services received | | | | |

**RECEIPT MUST SHOW: Date of Service, Provider's Name, Patient Name, Diagnosis, Charge for Each Service**
**NOTE: Your claim may require routing to verify provider network status**
**VISION/MASSAGE/ACUPUNCTURE CLAIMS: Diagnosis may not apply (will not route networks)**
**WRITE MEMBER ID ON EVERY PAGE SUBMITTED. KEEP A COPY OF RECEIPT(S) FOR YOUR RECORDS.**

## SEND PAYMENT TO:

| | | | | |
|---|---|---|---|---|
| | | **MEMBER** | | **PROVIDER** |

## EMPLOYEE RELEASE

Authorization to pay benefits to Employee

I hereby authorize payment of benefits directly to me for services, but not to exceed the reasonable and customary charge for said services. I understand I am financially responsible for any charges not covered by this authorization.

Covered Person _____ Date _____

## PATIENT OR PARENT MUST SIGN BELOW

Authorization to release information

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

Patient or Parent (if minor) _____ Date _____

Revised: 07/28/2014