UMR MEMBER CLAIM REIMBURSEMENT FORM

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

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

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** NOTE: Not including Member ID may result in a delay in processing

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
			TRAVEL EXPENSES RELATED TO QUALIFYING CLINICAL TRIAL				
			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: 01/30/2018