

MEDICAL CLAIM FORM

Use this form to submit reimbursement requests for services received from a non-network provider. Please complete a separate form for each family member. The time limit for filing claims is one year from the date of service/purchase. **Note:** This form may be used for claims for Uniform Medical Plan, UMP Classic, UMP CDHP, or UMP Plus. Network providers will submit claims to Regence directly.

1. Complete the information below and on the back of this form.
2. Attach itemized bills, including patient's name, date of service, diagnosis, procedures and charges.
3. Retain copies for your records. Receipts will not be returned.
4. Sign the completed form where indicated at the bottom of this page and submit the completed claim form to:

Regence BlueShield
 Attn: UMP Claims
 PO Box 1106
 Lewiston, ID 83501-1106
 or by fax to: 1-877-357-3418

Payments will be mailed to the address on file for the subscriber. You can verify your address by calling UMP Customer Service at 1-888-849-3681.

UMP Identification Number (include alpha characters)				
Patient's Last Name		Patient's First Name		MI
Patient's Date of Birth	Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse OR certified domestic partner (DP) <input type="checkbox"/> Dependent	Daytime Phone Number	
Subscriber's Last Name		Subscriber's First Name		MI
Group Name Uniform Medical Plan		Group Number		

OTHER INSURANCE INFORMATION

Are you or any family members on UMP covered by another plan? If so, please respond to the following:

Medical coverage? Yes No Vision coverage? Yes No
 Dental coverage? Yes No Prescription coverage? Yes No
 With Orthodontia? Yes No

If YES to any of the above, is this coverage: Group Individual

Are you or any family members covered by Medicare? Yes No (If YES, please specify: Part A Part B Part D)

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES," please complete the section(s) below. If you have more than one additional policy, attach information on a separate sheet of paper.

Name of Other Group Insurance Plan		Subscriber's Name	ID Number	Relationship to Subscriber	Date of Birth
Address for Submitting Claims			City	State	ZIP Code
This Coverage is For: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren) <input type="checkbox"/> Family		If children of divorced parents are covered by more than one plan, please indicate name of the person with legal custody.		Numbers that identify you to other group (ID numbers, etc.)	
Subscriber's Employer (if applicable)			<input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date of this Plan	

If the patient paid for services in cash, please indicate type of service received. _____

I hereby certify that all information given is correct and receipts are attached. I further certify that all services rendered or items purchased were for the family member named. I understand that it is a crime to knowingly provide false or misleading information and that doing so may result in civic or criminal prosecution.

Signature (Subscribe or Patient)

Date

UMP ID Number _____

Receipts must contain:

- Provider's name and address
- Provider's tax ID number (TIN)
- Provider's national provider identifier (NPI) number
- Diagnosis and procedure codes
- Itemized charges
- Date(s) of service

Name of illness and injury

Provider's name (if not on receipt)

If injury, date occurred

If injury, how, when, where

For each date of service please complete the following:

- Name of illness and injury
- Provider's name (if not on receipt)
- If injury, date occurred
- If injury, how, when, where

Name of illness and injury

Provider's name (if not on receipt)

If injury, date occurred

If injury, how, when, where

Name of illness and injury

Provider's name (if not on receipt)

If injury, date occurred

If injury, how, when, where