

Benefit Options

Choice. Value. Health.

MEDICAL CLAIM FORM

AZ Benefit Options - UMR
Group #: 3J

MAIL CLAIM TO:
AZ BENEFIT OPTIONS - UMR
P.O. BOX 30538
SALT LAKE CITY, UT 84130-0538
CUSTOMER SERVICE # 888-999-1459

INSTRUCTIONS FOR EMPLOYEE OR RETIREE FULLY COMPLETE PARTS 1 THRU 4 AS APPLICABLE. WHEN HOSPITAL AND/OR DOCTOR HAVE COMPLETED THE BOTTOM PORTION OF FORM, SUBMIT CLAIM TO THE ABOVE ADDRESS. **(A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH PERSON.)**

1	COMPLETE FOR ALL CLAIMS	EMPLOYEE OR RETIREE'S NAME (FIRST/MIDDLE/LAST)	MEMBER ID #	HOME TELEPHONE #	
		EMPLOYEE OR RETIREE'S HOME ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)			WORK TELEPHONE #
		ARE YOU, YOUR SPOUSE, OR YOUR DEPENDENT CHILDREN ENTITLED TO BENEFITS FROM ANY OTHER KIND OF GROUP HEALTH INSURANCE OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		IF YES, NAME AND ADDRESS OF OTHER INSURANCE COMPANY AND/OR ORGANIZATION WHERE CLAIMS ARE SUBMITTED.		POLICY #	<input type="text"/>
INSURANCE CO.: _____		SOCIAL SECURITY #	<input type="text"/>		
ADDRESS: _____					

2	MUST BE COMPLETED FOR AN ACCIDENT OR INJURY CLAIM	DATE OF ACCIDENT OR ILLNESS	HOUR	IS THE SICKNESS OR INJURY DUE TO: OCCUPATIONAL CAUSES? <input type="checkbox"/> YES <input type="checkbox"/> NO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
		MO. _____ DAY _____ YR. _____	A.M. _____ P.M. _____	
		WILL THE PATIENT FILE A CLAIM AGAINST A 3 RD PARTY LIABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF ACCIDENT: MOTOR VEHICLE? <input type="checkbox"/>
OTHER ACCIDENT? <input type="checkbox"/> _____				
GIVE A BRIEF DESCRIPTION OF THE ACCIDENT AND PLACE WHERE THE ACCIDENT OCCURRED (INCLUDING CITY AND STATE).				

3	COMPLETE ONLY FOR A DEPENDENT CLAIM	NAME OF PATIENT	RELATIONSHIP TO YOU	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
		IS THIS PATIENT EMPLOYED? (IF "YES," NAME AND ADDRESS OF HER OR HIS EMPLOYER) <input type="checkbox"/> YES <input type="checkbox"/> NO			

4	YOU MUST DATE AND SIGN	I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATIVE TO THIS CLAIM TO AZ BENEFIT OPTIONS - UMR AND DIRECT THAT BENEFITS BE MADE PAYABLE TO: <input type="checkbox"/> PROVIDER <input type="checkbox"/> MYSELF	SIGNED (EMPLOYEE)	DATE
		I CERTIFY THAT THE INFORMATION I FURNISH IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT. IF IS UNLAWFUL TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.	SIGNED (DEPENDENT PATIENT, AGE 18 & OVER)	DATE

MEDICAL/SURGICAL PHYSICIAN'S STATEMENT

Date of service To	Date of service From	Place of service *	# of visits	Procedure code	Fully describe procedures, medical services, or supplies furnished for each date given. (Explain unusual services or circumstances)	Diagnosis code	Charges

* Place of Service: Office, Hospital, Other	PATIENT'S ACCOUNT #	TOTAL CHARGES
PHYSICIAN'S NAME (PRINT) _____ DEGREE _____		AMOUNT PAID
		BALANCE DUE

STREET ADDRESS _____	CITY OR TOWN _____	STATE OR PROVINCE _____	ZIP CODE _____
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PHYSICIAN'S SIGNATURE _____	DATE SIGNED _____	TELEPHONE # _____	EMPLOYER ID# _____
MUST BE FURNISHED UNDER AUTHORITY OF LAW.			