SALARIED Non-Rep. CLAIM FORM INSTRUCTION AND FILING FACTS

FORM INSTRUCTIONS:

- Complete all questions as applicable.
- Accompanying bills/receipts must list patient's name, date(s) of service, diagnosis, applicable CPT code, facility revenue code or HCPCS code, amount charged for each service and provider's name.
- Submit itemized bills and the Explanation of Benefits (EOB) statement along with a claim form if you or your eligible dependents are covered by another insurance or Medicare as a primary carrier.
- All claims must be filed by December 31 of the year following the year in which service was provided.
- For mailing information refer to reverse side.

Questions concerning benefits and claims, call UMR at 1-800-367-7125

CLAIM FOR MEDICAL BENEFITS

1. EMPLOYEE / RETIREE / SURVIVING SPOUSE INFORMATION

A) Social Security No. _________-_______-____________ B) Payroll No. ________________ (active employee) C) Telephone No. ________________

D) Name ________________ Last Name ________________ First Name ______ MI E) Birthdate ___/___/___ Mo. Day Yr.

F) Address ________________ Street Address ________ City ________ State ________ Zip

2. PATIENT INFORMATION (DO NOT COMPLETE IF PATIENT IS THE ACTIVE EMPLOYEE: GO TO SECTION #3)

A) Patient Name ________________ Last ________________ First ______ MI B) Birthdate ___/___/___ Mo. Day Yr.

C) Male O Female O D) Patient Social Security Number __________-________-__________ ____

E) Relationship to the insured: Spouse O Child O Dependent stepchild O Other O________________

F) Is the patient employed? Yes, full time O Yes, part-time O No O

Working spouses are required to enroll in their employer's group health care plan if coverage is available.

G) Name, address and phone number of patient's employer (if applicable) ________________ Name of Employer

________________ Street Address ________ City ________ State ________ Zip ________ Phone Number

H) Is the patient covered by another employer health insurance, welfare or government plan for medical expenses? Yes O No O;

If not, is coverage available to you and if not now when? Yes O No O Date coverage will be available O________________

I) If yes, name and address of other plan ________________ Name of Plan

________________ Street Address ________ City ________ State ________ Zip ________ Phone Number

3. MEDICARE INFORMATION

A) Is the patient covered by Medicare? Yes O No O Effective date of coverage ___/___/___ Mo. Day Yr.
(If no, go to Question 4.)

B) Is your Medicare coverage due to kidney dialysis? Yes O No O C) Is your Medicare due to disability? Yes O No O

D) What type of Medicare coverage do you have? Part A O Part B O

4. ACCIDENT INFORMATION

A) Is this claim due to an accident or injury? Yes O No O B) Is this claim the result of a work-related illness or injury? Yes O No O

If "yes", name and address of employer ________________

Full time employee O Part time employee O

C) Was accident or injury due to O Auto or O Other D) Date accident occurred ________________

E) Explain where and how accident occurred

____

F) If applicable, list name, address and telephone number of your auto or homeowner's insurance company

____

G) Name, address and phone number of insurance company of any third party involved with the loss ________________

____

H) Was a police report filed? Yes O No O (If yes, you must submit a copy of the report to UMR).

I) Do you intend to seek restitution of medical / dental expenses and/or work time lost for you or your dependent?
Yes O No O Uncertain at this time O J) Will you file for any disability benefits? Yes O No O Uncertain at this time O

K) Will you contact an attorney in this matter? Yes O No O Uncertain at this time O

L) If yes, list attorney's name, address, and telephone number ________________

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CONTINUED ON BACK

IMPORTANT STATEMENT (PLEASE READ BEFORE SIGNING FORM)

In filing this claim, I attest that the information provided by me is correct and I authorize I/N TEK & I/N KOTE or its authorized representatives, including the Social Security Administration, to release any information required for its processing, auditing, quality assurance, or utilization review programs, realizing it may also be used in the investigation of this claim and other claims against the company for which the information may be relevant and satisfy reasonable business purpose. I further authorize my medical provider to release my medical record or that of my covered dependents, which is necessary for use by I/N TEK & I/N KOTE for the processing of the claim, or for auditing, quality assurance or utilization review programs. Any person who knowingly files a statement of claim containing any false, incomplete or misleading information may be guilty of criminal offense. I understand that any omission or misrepresentation of material fact may be considered just cause for rejection of this claim. Active employees can be subject to disciplinary actions including suspension subject to discharge. Individuals receiving benefits under provisions of this plan agree to subrogate any rights to payments or reimbursement personally or for the account of the insured or covered dependent as a result of legal action or settlement against a third party. In filing this claim, I and my covered dependents acknowledge and agree that the right to subrogation of I/N TEK & I/N KOTE and / or the Plan is the right to be fully reimbursed for all payments or benefits paid by or on behalf of I/N TEK & I/N KOTE or the Plan, from the first dollar paid by any source of any recovery (whether deemed for personal injury or reimbursement of medical payments or any other reason) up to and including the full extent of payments made by or on behalf of I/N TEK & I/N KOTE and / or the Plan, whether or not the claimant has fully recovered for all personal injury or expenses incurred.

X ______________________ Signature (Insured) ________ Date

X ______________________ Dependent Patient's Signature (if age 18 or over) ________ Date

NOTE: If all sections of the claim form are not completed or if it is mailed to the wrong address, the claim form will be returned to you; the processing of the charges will be delayed.

PROVIDER'S STATEMENT

Physicians may complete Provider's Statement below or attach a substitute form if it includes all of the information requested. All bills must show patient's name, date(s) of service, diagnosis, applicable CPT Code, facility revenue code or HCPCS code, amount charged for each service and provider's name.

DIAGNOSIS (ICD-9) CODE(S): PATIENT ACCOUNT #:

DATE(S) OF SERVICE(S)	PLACE OF SERVICE(S)	CPT-CODE	MEDICAL / SURGICAL SERVICE(S) RENDERED	CHARGE

*O - DOCTOR'S OFFICE IH - INPATIENT HOSPITAL NH - NURSING HOME

H - PATIENT'S HOME OH - OUTPATIENT HOSPITAL OL - OTHER LOCATIONS

TOTAL CHARGES ☐ $ ________

AMOUNT PAID ☐ $ ________

BALANCE DUE ☐ $ ________

Practitioner - SS No.

Tax I. D. No.

Must be furnished under Authority of Law

PROVIDER NAME (Please Print)

M.I. **LAST** **SPECIALTY**

TELEPHONE NO.

CITY **STATE** **ZIP**

TO SEND COMPLETED FOR PROCESSING, YOU CAN USE EITHER OF THE FOLLOWING WAYS:

- Fax Completed Form to 877-293-4926
- Email Completed Form to umr-claimsubmission@umr.com

MAIL COMPLETED FORM TO:

UMR - I/N Tek & I/N Kote
P.O. BOX 30541
SALT LAKE CITY, UT 84130-0541