

Do not staple
in this area.



**Uniform
Medical Plan**
Your health. Your plan. Your choice.

Claim Form

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were received from a Uniform Medical Plan PPO (UMP PPO) or UMP Neighborhood network provider and either plan is primary (pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. Do not use this form for prescription drug or dental claims.

Questions? Uniform Medical Plan PPO enrollees: 1-800-762-6004; or 425-670-3000 (Seattle)
UMP Neighborhood enrollees: 1-888-380-2822; or 425-686-1218 (Seattle)

Section 1 – Subscriber Information

A. Uniform Medical Plan Identification No.

B. Subscriber Name _____ Birth Date ____/____/____
Last Name First Name M.I. Mo. Day Yr.

C. Subscriber Home Address _____
Street Address

City State ZIP Code + 4 Work Phone Number Home Phone Number

D. Has your address changed since your last claim? Yes No

Section 2 – Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name _____ Birth Date ____/____/____
Last Name First Name M.I. Mo. Day Yr.

B. Relationship to subscriber
 Spouse Qualified same-sex domestic partner
 Dependent child under age 20 Registered student dependent age 20-23
 Dependent stepchild under age 20 Other Specify _____

C. Is patient employed? Yes, full-time Yes, part-time No

If yes: _____
Name of Employer

City State ZIP Code + 4 Employer's Phone Number

Section 3 – Provider Information

Complete this section if the provider information is not included on the bill.

_____ <small>Provider Name</small>	_____ <small>Provider Name</small>
_____ <small>Specialty</small>	_____ <small>Specialty</small>
_____ <small>Address</small>	_____ <small>Address</small>
_____ <small>City State ZIP Code + 4</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	_____ <small>City State ZIP Code + 4</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<small>Tax I.D. Number (if known)</small>	<small>Tax I.D. Number (if known)</small>

PLEASE COMPLETE REVERSE SIDE

Section 4 – Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? Yes No

B. Is this claim due to any accident or injury? Yes No

If you answered no to both questions, go to Section 5.

C. Was illness or injury due to Auto accident Other Specify _____

D. Date accident occurred _____ / _____ / _____
Mo. Day Yr.

E. Was a police report filed? Yes No **If yes, you must submit a copy of the police report with this claim.**

F. Explain where and how the illness or injury occurred _____

G. Your auto or homeowner's insurance company _____

Name of Insurer

Street Address

City

State

ZIP Code + 4

Phone Number

H. Insurance company of another party involved with this loss _____

Name of Insurer

Street Address

City

State

ZIP Code + 4

Phone Number

I. Do you intend to seek repayment of medical expenses or work time lost for you or your dependent?

Yes No Uncertain at this time

J. Will you file for any disability benefits? Yes No Uncertain at this time

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

L. If yes _____
Name of Attorney Phone Number

Section 5 – Other Coverage

A. Are patient's medical expenses covered by another employer's group health insurance, welfare, or government plan? Yes No

If yes, and the other plan is primary, attach a copy of the Explanation of Benefits from the other plan to expedite processing.

If yes, name of policyholder on other coverage _____
Name

Street Address

City

State

ZIP Code + 4

Name of Plan

Group Number

B. Is patient covered by Medicare? Yes No

If no, go to Section 6. If yes, please submit a copy of the Explanation of Medicare Benefits.

C. What type of Medicare coverage does patient have? Part A (Hospital) Part B (Physician)

If patient is under age 65:

D. Is Medicare coverage due to kidney disease? Yes No

E. Is Medicare coverage due to disability? Yes No

Section 6 – Authorization to Pay

Have you paid for these charges? Yes No **UMP pays network providers directly.**

I certify this information is correct and authorize its release as required for administration of this claim.

Please note that personal information you may be required to submit to the Uniform Medical Plan, including medical records, will be disclosed only according to guidelines in the UMP Notice of Privacy Practices, which is available on the UMP Web site at www.ump.hca.wa.gov, or by calling customer service (see page 1).

Signature of Subscriber/Patient (Parent, if minor)

Date