TEXAS FARM BUREAU HEALTH PLANS

UMR

EZ Claim Form Medical/Dental/Vision

Staple itemized statement or receipt here to the back of this form

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to item #6 on the back of this form for the items required for claim submission. **If sufficient documentation is not received, claim will not be processed.**

Name of Plan: Texas Farm Bureau Health Plans

Plan Group Number: 76-415319

Name of Subscriber: _____

Subscriber ID _____

Patient's Name: _____

Date of Birth: _____

Subscriber Phone Number and/or Email Address: _____

Issue Payment to: ☐ Member ☐ Provider

Provider Name: _____

Provider Tax ID # 9 Digits: **(USA only)** _____

(required field - please contact your provider if statement is missing this information)

Provider Address: _____

Type of Service	Check all that apply. **PLEASE NOTE - ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.**				
☐ Vision	☐ Exam	☐ Frame	☐ Lenses	☐ Contacts	☐ Other
☐ Medical	☐ Office Visit	☐ Flu Shot	☐ Breast Pump		
	☐ Lab	☐ Immunization	☐ Durable medical equipment		
	☐ X-Ray		☐ Other		
☐ Dental	**A detailed itemized statement is required from your dental provider**				

Is claim related to an accident?: ☐ No ☐ Yes

If yes, provide details including date, description and location of accident.

Is patient covered by another plan? ☐ No ☐ Yes

If yes, type of other coverage: ☐ Medical ☐ Dental ☐ Vision

Carrier: _____ Group Number: _____

Subscriber Name: _____ ID Number: _____

Name of Plan: _____

You may submit your claim to UMR by one of the following methods:

FAX: 855-405-2189

Mail:
UMR
PO Box 8033
Wausau WI 54402-8033

Email a pdf of your claim and documents to:
UMR-ClaimSubmission@UMR.COM

See back of form for complete claim filing instructions

Filing your claim is easy. Please review these important tips.

1 Use this form to file a claim for any eligible medical expense when your physician or other provider does not file a claim. Please print clearly with black ink completing all required fields.

2 Attach your itemized statement (or fully legible copy of the bill) to the back of this form. Keep a copy for your records.

Please use a separate claim form for each health care professional and for each family member.

3 See your FBHP/UMR ID card for:
*Name of Plan
*Plan Group Number
*Name of Member (as it appear on the ID card)

4 Patient name and date of birth must match FBHP/UMR's eligibility file.
Example - if your name was Eugene Smith on your enrollment form, claim must state Eugene, not Gene

5 Name, address and Tax ID number of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the receipt, you can contact their office to obtain it.

6 To be considered a valid claim, (with the exception of gym memberships) your bill should include the following information:
-Patient name
-Date of service
-Description of service (i.e.: office visit, injection, immunization, glasses)
-Diagnosis (type of illness or injury)
-A charge of each service
-Name, address and Tax ID number of the provider (required field for services rendered in the US or US territories)

7 If your plan other services not considered traditional medical expenses, the information needed to file a claim can vary. Date of service and diagnosis may not apply.

8 Balance Due Statements are not valid claims. See above for information needed to constitute a valid claim.

9 Your submission will be scanned. Staple any attachments to the back of the claim form, not the front. Additionally, please indicate the member number on any attachments, should paperwork be separated from the claim form.

10 Claim address listed on the bottom of the claim form is for member use only; providers should bill to the address on the member ID card. This fax number also supports international faxing.

11 Prescriptions/drug charges that are allowable should be submitted on a Prescription Drug Claim Form.