ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST

UMR MEMBER CLAIM REIMBURSEMENT FORM

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information listed below.

Submit claims to: UMR - Attn: Miranda M
169 Inverness Drive West
Englewood, CO 80112
Fax: 844-226-3383
Email: miranda.mccullough@umr.com

EMPLOYEE INFORMATION

Please Check Your Plan:

- ☐ **Archdiocese of Denver - Group #76-412838**
- ☐ **Diocese of Colorado Springs - Group #76-412878**
- ☐ **Catholic Charities of Denver - Group #76-412879**

EMPLOYEE - LAST, FIRST, MI			**MEDICAL ID NUMBER WITH UMR**
STREET ADDRESS		CITY	STATE
ZIP	DATE OF BIRTH	PHONE NUMBER	EMAIL

PATIENT INFORMATION (if other than employee)

LAST NAME, FIRST, MI	RELATIONSHIP TO EMPLOYEE:

PROVIDER INFORMATION

PROVIDER NAME:	ICD-10 DIAGNOSIS CODE(S):	PROCEDURE CODE(S):
PROVIDER PHONE NUMBER:	PROVIDER TAX ID (9 digits):	

TYPE OF SERVICE (check all that apply)

☐	SPIRITUAL CARE (Copay & Choice PPO Plan - reimbursed at 50%)
☐	NATURAL FAMILY PLANNING (Copay, Choice PPO & Security Plus Plan - reimbursed at 100%)
☐	ACUPUNCTURE, CHIROPRACTIC, MASSAGE THERAPY, NATUROPATHY (Copay & Choice PPO Plan - reimbursed at 50%)
☐	BEHAVIORAL HEALTH (mental health, substance abuse)
☐	OTHER (briefly describe):

RECEIPT MUST SHOW: Date of Service, Provider's Name, Patient Name, Diagnosis, Charge for Each Service

NOTE: Your claim may require routing to verify provider network status

WRITE MEMBER ID ON EVERY PAGE SUBMITTED. KEEP A COPY OF RECEIPT(S) FOR YOUR RECORDS.

SEND PAYMENT TO (check one):

☐ **MEMBER** ☐ **PROVIDER**

EMPLOYEE RELEASE

Authorization to pay benefits to Employee

I hereby authorize payment of benefits directly to me for services, but not to exceed the reasonable and customary charge for said services. I understand I am financially responsible for any charges not covered by this authorization.

Covered Person ______________________ Date ______________________

PATIENT OR PARENT MUST SIGN BELOW

Authorization to release information

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

Patient or Parent (if minor) ______________________ Date ______________________

Revised: 07/13/2017