

Wrap Plan Claim Form

*(do not use this form if not on Wrap plan)*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explanation of benefits from primary insurance carrier attached? \_\_\_\_\_

Pay employee or provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Service: | Provider Name: | Type of Service: | Amount Requested: |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  | Total Reimbursement Requested: |  |

Member’s signature Date

|  |
| --- |
| You may submit your claim to UMR by one of the following methods – include completed claim form and supporting documents: |
| **FAX:** 855-405-2189 | **Mail:** UMRPO Box 8033Wausau WI 54402-8033 | **Email:**UMR-claimSubmission@umr.com |