Staple itemized statement or receipt to the back of this form

Member Vision Claim Submission Form

IMPORTANT: We recommend all vision receipts be submitted online. You can do this by signing in to **umr.com**. Once you're signed in, select the **Claims** drop-down menu in the blue navigation bar. Under **Other tools**, select **Submit a claim**. Then, select **Submit an online claim**.

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 filing instructions included for the supporting documentation required for claim submission. **Sufficient documentation is required for the claim to be processed.**

Personal information

Name of employer ______________________

Name of employee ______________________

Patient's name ______________________

Plan group number ______________________

Member ID ______________________

Date of birth ____ / ____ / ____ (MM DD YY)

Employee phone number and/or email address ______________________

Issue payment to Member Provider

Facility name ______________________

Provider name ______________________

Provider address ______________________

Date of purchase/service: ____ / ____ / ____ (MM DD YY)

Provider 9 digit tax ID#* ______________________

*Required field – See filing instructions for online TINS or contact your provider to obtain information.

Check all that apply. **List dollars paid in front of each checked item. Make sure the total paid matches the attached receipt. Please note: All service types may not be covered under your plan. When entering the total amount paid, subtract any discounts, shipping and handling/delivery fees or sales tax.**

Reason for vision exam (check one):	Routine annual vision exam	Medical vision exam (i.e., glaucoma, diabetic).
	Provide reason for visit: ______	

Charges incurred:

Vision exam, Paid $ ________ Refraction, Paid $ ________

Lenses:	Single lenses, Paid $ ______	Progressive lenses, Paid $ ______
	Bifocal Lenses, Paid $ ______	Lens coating, Paid $ ______
	Trifocal lenses, Paid $ ______	Other, Paid $ ______
	Lenticular lenses, Paid $ ______	Description: ______
Contact lenses:	Lens fitting, Paid $ ______	Contacts, Paid $ ______
Glasses:	Frames, Paid $ ______	
	Safety glasses, Paid $ ______	

Total amount paid: $ ________

(Continued)

Please describe services rendered if you are unable to match to categories on previous page:

___

___

___

Filing instructions:

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

Email a PDF of your claim and documents to:

UMR-claimsubmission@umr.com

Fax:
855-444-2896

Mail:
UMR, PO Box 30541
Salt Lake City, UT 84130-0541

1. Use this form to file a claim for any eligible vision charges. Please print clearly with black ink completing all required fields.
2. Attach your itemized statement (or fully legible copy of receipts) to the back of this form. Keep a copy for your records.
   a. Please indicate the member ID number on any attachments.
   b. Staple any attachments to the back of the claim form, not the front.
3. Please use a separate claim form for each family member.
4. Use your UMR ID card for:
   a. Name of employer
   b. Plan group number
   c. Name of member (as it appears on the ID card)
5. Patient name and date of birth must match UMR's eligibility file.
   a. For example, if your name is Eugene Smith on your employer enrollment form, claim must state Eugene, not Gene.
6. Name, address, and Tax ID number (TIN) of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the itemized statement or receipt, you can contact their office to obtain it.
7. Balance due statements are not valid statements or receipts. See above for information needed to constitute a valid claim.

Below are some confirmed online Provider TINs. Please use only when appropriate:

Facility	TIN
1-800 Contacts	870571643
Frames Direct	760459412
Glasses USA	981385007
Warby Parker	800423634
Zenni	454185057
Contacts Direct	311339854
EyeBuyDirect	203678882

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