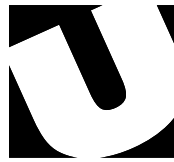
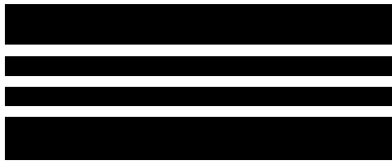


Do not staple
in this area.



**Uniform
Medical Plan**

Your health. Your plan. Your choice.

Medical Claim Form

Notes

- Use this form for medical services from non-network providers, or if UMP is your secondary coverage and the provider won't bill UMP. Medicare will bill UMP; Medicare retirees need not send in claims.
- Use the *Prescription Drug Claim Form* for prescription drug purchases.
- Use the *Vision Hardware Claim Form* for purchases of eyeglasses or contact lenses.

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charges.
3. Mail to: **Uniform Medical Plan, PO Box 34850, Seattle, WA 98124-1850.**

Questions? Call 1-800-762-6004 (425-670-3000 in the Seattle area)

Section 1 Subscriber Information

A. Uniform Medical Plan Subscriber ID 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 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.

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

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 Part B
(Hospital) (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