



Vision Hardware Claim Form

Information We Need to Process Your Claim

Information About You

UMP Subscriber ID No. W _____

Primary Subscriber Name _____

Patient Name _____

Patient Birthdate (mm/dd/yyyy) ____/____/____

Patient relationship to subscriber _____

Your daytime phone number _____

Include a Valid Receipt

Enclose a receipt* that includes:

- A description of what you purchased (glasses, contact lenses)
- Date of purchase
- How much you paid
- Name of provider/vendor (preferably with contact information, such as a phone number or address)
- *Optional:* If your provider has given you a claim form to submit, please include it.

**Note: A cash register receipt is usually not sufficient. Please keep a copy of the receipt and this form for your records.*

Information About Your Vision Care Provider

Please fill in *either* the tax identification number (TIN), *or* the provider's business name, address, and phone number.

Provider Tax Identification Number (TIN)

(if available): _____

—OR—

Provider Business Name _____

Provider Address

Street *Suite*

City *State* *ZIP*

Phone (including area code) _____

What Is the Purpose of This Form?

To help you get reimbursed for the purchase of prescription contact lenses or eyeglasses. Fill out this form and send it with a **valid receipt** to UMP.

Where Do I Send This Form?

Mail to: Uniform Medical Plan
PO Box 34850
Seattle, WA 98124-1850

How Long Will It Take to Get My Money?

You should receive your money within 30 days after we receive your claim.

Where Will My Payment be Mailed?

We will mail the check to the address on file for the subscriber.

To check your address:

Call UMP Customer Service at 1-800-762-6004.

To change your address:

Active employees — Contact your personnel, payroll, or insurance office.

Retirees

— Contact:
Health Care Authority
PO Box 42684
Olympia, WA 98504-2684
Or call 1-800-200-1004

Questions?

Call UMP Customer Service at 1-800-762-6004

Please Sign Here

I certify this information is correct and authorize its release as required for administration of this claim.

Signature of Patient (or parent, if patient is a minor)

Date