



MEDICAL AND DENTAL CLAIM FORM
THE WELFARE FUND OF PLUMBERS LOCAL UNION #200
GROUP NUMBER: 0081636

Part A – Patient & Employee Information (Please Print or Type)

Patient's Name: Last-First-Middle	Patient's Birthdate	Employee's Name: Last-First-Middle
Phone Number Area Code ()	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's Identification Number
Patient's Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Employee's Home Address	
City	State	Zip Code

Part B – Medical or Dental & Accident Information

Please give Patient's diagnosis or description of medical condition:
If accident related, please give date accident occurred: _____/_____/_____
Did the accident involve a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the accident occur while on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the accident or injury:

Part C – Other Insurance *Complete this Section only if the patient is covered by other insurance or Medicare.*
(Attach Explanation of Benefits from Other Insurance Company)

Name of Covered Person	Covered Person's Social Security Number	Name of Covered Person's Employer
Other Insurance Company Name	Other Insurance Company Address	
If patient is eligible for Medicare, please give Medicare Identification Number		

Part D – Employee's Signature & Date *(Please attach patient's original itemized bill to this form)*

I certify that the above information is complete and accurate to the best of my knowledge and that benefits are being claimed only for expenses incurred by the named patient. I understand that any intentional false statements or willful misrepresentations may result in legal prosecution. I authorize any provider of service in possession of any medical information concerning the patient to release such information to you upon request. I understand that itemized bills or statements submitted with a claim cannot be returned.	
Employee's Signature _____	Date _____

Please refer to reverse side of this form for helpful information on how to file your claim.

Helpful Information for Filing Your Claim

- Complete all requested information in sections A, B, C, and D on this claim form. A separate claim form should be used for each family member. Claim form must be signed and dated by the employee.
- Attach all original itemized bills for the patient to this claim form. Obtain photocopies of items needed for your records, as original bills will not be returned to you.
- If the patient also is covered by any other health insurance or by Medicare, please attach the Explanation of Benefits that corresponds to the itemized bills.
- Mail your completed claim form with itemized bills to:

UMR
Claims Department
2700 Midwest Drive
Onalaska, WI 54650-8763

Points To Remember

Any person who knowingly and with intent to defraud any employee benefit plan or plan representative, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

For accurate claims processing, we must be able to identify each service you received, when it was received, who provided the service, and the amount charged. Because many bills list more than one service, make sure that all bills are properly itemized. Canceled checks and receipts of payment do not contain the information outlined below and are not acceptable.

Claim forms are available from your employer. Participating providers are required to file claims directly with us.

Every Health Care Provider's Bill Must Include the Following:

- Provider's name and address on a preprinted bill form or the provider's original signature
- Patient's full name
- Diagnosis
- Date each service was received (month, day, year)
- Description of each service
- Amount charged for service