



EZ Claim Form Medical/Dental/Vision

Name of Plan: Indiana Farm Bureau Health Plans **Group# :** 76-414558

Name of Subscriber: _____ **ID#:** _____

Patient's Name: _____ **Date of Birth:** ____/____/____
(Last Name, First, Middle Initial)

Is claim related to an accident: No Yes

If yes, provide details including date, description and location of accident.

Is patient covered by another group plan? No Yes

If yes, type of other coverage: Medical Dental Vision

Carrier: _____

Group Number: _____ Subscriber Name: _____

ID Number: _____ Name of Plan: _____

Please attach your physician's statement.

THE FOLLOWING INFORMATION MUST BE ON YOUR RECEIPT OR ON YOUR PROVIDER INVOICE AND SUBMITTED WITH THIS CLAIM FORM IN ORDER TO PROCESS YOUR CLAIM (PLEASE CHECK EACH BOX):

- | | |
|--|--|
| <input type="checkbox"/> Date of Service | <input type="checkbox"/> Diagnosis Code |
| <input type="checkbox"/> CPT (Procedure) Code | <input type="checkbox"/> Provider Tax Identification Number (TIN) Billed |
| <input type="checkbox"/> Provider Name & Address | <input type="checkbox"/> Charges and Amount Member Paid |

For vision claims, please attach a detailed receipt.

For prescription claims please complete a Prescription Drug Claim form.

Issue Payment to: Provider or Subscriber

(Subscriber Signature) - Not required if signature is on file.

(Date)

As a member, you may submit your claim to UMR by one of the following methods:

Fax claims to:
855-444-2896

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

Email a .pdf of your claim to:
umr-claimsubmission@umr.com