

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. Go to umr.com, sign in, click on “submit Claim” under “I need to” on the left side of the portal. If you do not have internet access complete the form below. 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 claim to be processed.**

Personal information

Name of employer _____ Plan group number _____

Name of employee _____ Member ID _____

Patient's name _____ Date of birth / /
MM DD YY

Employee phone number and/or email address _____

Issue payment to Member Provider Date of purchase/service: / /

MM DD YY

Facility name _____ *Provider

Provider name _____ 9 digit tax ID# _____

Provider address _____ *Required field. See timing instructions for online forms or contact your provider to obtain information.*

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

Check all that apply. List dollars paid behind each checked item. Make sure the total paid by member matches the attached receipt. **Please note: All service types may not be covered under your plan.** When entering the total amount paid, exclude 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:

Changes incurred:

Vision exam, Paid \$ _____ Frames, Paid \$ _____

Lenses:

Single lenses, Paid \$ _____

Bifocal Lenses, Paid \$ _____

Trifocal lenses, Paid \$

Lenticular lenses, Paid \$

Progressive lenses, Paid \$ _____

Lens coating, Paid \$

Other, Paid \$

Description:

Contact lenses:

Lens fitting, Paid \$

Contacts, Paid \$

Glasses:

Safety glasses, Paid \$

Total amount paid by member: \$

(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 UMRs eligibility file.
 - a. 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