



Disputed Claims Form

Claim information

Name of health plan

Compass Rose Health Plan

Group number 76-411449

Patient name

Health plan member ID#

Subscriber name

Patient date of birth

(MM/DD/YYYY)

Claim control number

Date of service (MM/DD/YYYY)

Provider name

Total billed amount on claim

Name of individual disputing the claim referenced above

Phone number

Email

Today's date (MM/DD/YYYY)

Brief description of dispute

Please mail this completed form along with any supporting documents to:

UMR – CRBG Appeals

P.O. Box 8080

Wausau, WI 54402-8080

For questions, please call UMR at **888-438-9135**.

Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file. This form is to be utilized for initial claims disputes. If you have already received a claims appeal which has been upheld, and do not agree with our decision, you may ask OPM to review it.

You must write to the Office of Personnel Management (OPM) within:

- **90 days** after the date of our letter upholding our initial decision; or,
- **120 days** after you first wrote to us — if we did not respond to that request in some form within 30 days; or,
- **120 days** after we asked for additional information.

For more information on the disputed claims process, please refer to Section 8 of the Compass Rose Health Plan FEHB plan brochure.