Stateside Claim Form: Medical/Dental

As a Compass Rose Health Plan member, you may submit claim(s) to UMR by one of the following methods:

- **Mail claims to:** UMR, P.O. Box 8095, Wausau, WI 54402-8095
- **Fax claims to:** (855) 405-2189

If you have questions, call **UMR Customer Service:** (888) 438-9135

Important: Prescription drug claims should be submitted seperately using Optum Rx®'s claim form. For a copy, please visit **compassrosebenefits.com/Rx**.

Name of Health Plan: Compass Rose Health Plan **Group Number:** 76-411449

Patient's Name: _____ **Health Plan Member ID#:** _____

Patient's Date of Birth (MM/DD/YYYY): _____ **Subscriber Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Email:** _____

Is this claim related to an accident? ○ Yes ○ No

If Yes: **a. Date of accident (MM/DD/YYYY):** _____

b. Provide details (i.e description/location of accident): _____

_____

_____

_____

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:

- ○ Date of service
- ○ CPT (procedure) code
- ○ Provider tax identification number (TIN)
- ○ Diagnosis code
- ○ Provider name
- ○ Billed charges/amount paid

Issue payment to:

○ Member ○ Provider

_____ _____ _____

Member signature Print member name Date