Health Claim Form

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

UMR
A UnitedHealthcare Company

1. Please complete items 1 through 8 in full.
2. Please complete items 8 through 11 only if you have other medical coverage, including Medicare.
3. Please be sure to sign the authorization so we can release information on items 12 and 13 if necessary.
4. If you have submitted a request for benefits under another health plan (including Medicare), please attach a copy of the bills you sent to the other plan and the Explanation of Benefits form the plan sent to you.
5. Attach itemized bills or ask your health care provider to complete the applicable section. The bills must include:
   a. Patient's name
   b. Date(s) of service
   c. Condition being treated
   d. Relationship to employee
   e. Type of service(s) given

   If any of this information missing, simply write it on the bill and sign your name.
6. Keep copies of your bills for your records.
7. The mailing address for claims is on the back of your ID card. UMR, PO Box 30541, Salt Lake City, UT 84130-0541

Employee information

1. Subscriber identifier (SSN or ID#) | Group number

NVPEB

2. Patient's name (Last, first, middle)

3. Patient's date of birth (MM DD YYYY) | Gender: M ◯ F ◯

4. Employee's name (Last, First, Middle)

5. Patient's address

Street

City ST Zip

6. Patient's relationship to employee

Self ◯ Spouse ◯ Child ◯ Other ◯

7. Employee's address

Street

City ST Zip

8. Patient status

Single ◯ Married ◯ Other ◯

Employed? Yes ◯ No ◯

Full time student? Yes ◯ No ◯

Part time student? Yes ◯ No ◯

9. Other insured's name (Last, first, middle)

a. Other insured's policy or group number

b. Other insured's date of birth (MM DD YYYY)

c. Employer's name or school name

d. Insurance plan name or program name

10. Is patient's condition related to:

a. Employment? (current or previous) Yes ◯ No ◯

b. Auto accident? Yes ◯ No ◯

c. Other accident? Yes ◯ No ◯

d. Please provide accident details:

11. Employee's policy/group number

a. Employee's date of birth (MM DD YYYY)

b. Claims administrator **UMR, PO Box 30541, Salt Lake City, UT 84130-0541 www.umr.com**

c. Is there another health benefit plan? (additional coverage) Yes ◯ No ◯ (If **Yes**, return to and complete item 9 a-d)

12. Patient's or authorized person's signature

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed (MM DD YYYY)

13. Authorized person's signature

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed (MM DD YYYY)

Physician and supplier form on reverse side.

Physician or supplier information

14. Date of current illness (first symptoms) or injury (accident) or pregnancy (LMP)

MM DD YYYY

15. If patient has had same or similar Illness give first date

MM DD YYYY

16. Date patient unable to work in current condition

From MM DD YYYY To MM DD YYYY

17. Name of referring physician or other source

18. I.D. number of referring physician

19. Hospital dates related to current services

From MM DD YYYY To MM DD YYYY

Physician or Supplier: Complete items 14 through 33 in full. If the employee indicates benefits should be paid directly to you, then these benefits will be sent directly to you and an informational copy of the transaction will be sent to the employee.

20. Outside lab?

Yes ◯ No ◯ $ Charges

21. Diagnosis or nature of illness or injury (relate items 1,2,3 or 4 to item 24E by line)

1	
2	
3	
4	

22. Medicaid resubmission

23. Prior authorization number

24.	**A**		**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
	Dates of services To	From	Place of service	Type of service	Procedures, service, or supplies (explain unusual circumstances) **CPT HCPCS** **Modifier**	Diagnosis code	Charges	Days or units	EPSOT fam plan	EMG	COB
1	DD/MM/YY	DD/MM/YY									
2	DD/MM/YY	DD/MM/YY									
3	DD/MM/YY	DD/MM/YY									
4	DD/MM/YY	DD/MM/YY									
5	DD/MM/YY	DD/MM/YY									
6	DD/MM/YY	DD/MM/YY									

25.

Fed Tax ID	
SSN	
EIN	

26. Patient account number	
27. Accept assignment?	
28. Total charge	
29. Amount paid	
30. Balance due	

32. Name/address of facility where services were rendered

Street

City ST Zip

33. Physician/supplier billing address

Name

Street

City ST Zip

PIN number	Group number

31. Signature of physician or supplier — Signed — Date MM DD YYYY