Staple itemized statement or receipt here to the back of this form

Member Claim Submission Form

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 item #6 on the back of this form for the supporting documentation required for claim submission. **If sufficient documentation is not received, claim will not be processed.**

Name of Plan: South Dakota Farm Bureau Health Plans Plan Group Number: 76-414989

Name of Member: ______________________ Member ID: ______________________

Patient's Name: ______________________ Date of Birth: ______________________

Member Phone Number and/or email address: ______________________

Issue Payment to: ☐ Member ☐ Provider

Provider Name: ______________________ *Provider 9 Digit Tax ID # (USA only): ____________

(required field - please contact your provider if statement is missing this information)

Provider Address: ______________________

Type of Service	Check all that apply. **Please note - ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.**
☐Medical/Dental	☐ Office Visit ☐ X-Ray/Lab ☐ Immunization ☐ Prescription/Drug ☐ Breast Pump ☐ Other ☐ COVID-19 **DENTAL - A detailed itemized statement is required from your dental provider**
☐Vision	☐ Exam ☐ Frame ☐ Lenses ☐ Contacts ☐ Other
☐Travel	☐ Car Rental ☐ Hotel ☐ Mileage/Gas ☐ Meals ☐ Airfare ☐ Other ☐ Apartment Rental ☐ Tolls/Parking
☐Foreign	☐ Office Visit ☐ Hospital ☐ Emergency ☐ Lab ☐ X-Ray ☐ Prescription ☐ Other Date of Service: ____________Country:____________ Charges in USD: $____________ Diagnosis: ____________

Note: *If you checked Other, please complete the information below:*

Please use this space to briefly describe services rendered:

You may submit your claim to UMR by one of the following methods:

Fax: 855-444-2896

Mail:
UMR
PO Box 8033
Wausau WI 54402-8033

Email a PDF of your claim and documents to:
UMR-ClaimSubmission@UMR.com

Filing your claim is easy. Please review these important tips.

1. Use this form to file a claim for any eligible medical claims or medical related travel and lodging expenses. Please print clearly with black ink completing all required fields.

2. Attach your itemized statement (or fully legible copy of travel and lodging receipts) to the back of this form. Keep a copy for your records.
    a. Please use a separate claim form for each health care professional and for each family member.

3. 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)

4. 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

5. Name, address and TAX ID number 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.

6. To be considered a valid claim, you should include as much supporting information as possible, the following information should be included as outlined below:

    Medical Claims
    1. Patient name
    2. Date of service
    3. Description of service (i.e. office visit, injection, immunization)
    4. Diagnosis (type of illness or injury)
    5. Charge amount for each service
    6. Name, address and TAX ID of the provider (required field for services rendered in the US or US territories)

    Incurred Expense Receipts – T&L
    1. Copies of any companion expenses (e.g. airfare/meals)
    2. Hotel daily reimbursement limit up to $50.00 (single)/$100.00 (patient + companion)
    3. Mileage
    4. Car rental
    5. Meal (etc.)

7. Balance due statements are not valid statements or receipts. See above for information needed to constitute a valid claim.

8. Staple any attachments to the back of the claim form, not the front. Additionally, please indicate the member ID number on any attachments.