Member Reimbursement Form

Group:	Quapaw Tribal Member Plan	Group #:	76-413761
Member:		Member ID#:	
	(Last Name, First Name, Middle Initial)		(Located on Medical ID Card)
Phone number:		Patient Date of Birth:	
			(mm/dd/yyyy)

Is claim related to an accident?	◯ Yes	◯ No
Is patient covered by another group plan?	◯ Yes	◯ No

CLAIM INFORMATION

Claim Type	Date of Service dd/mm/yyyy	Provider Last Name	$ Amount Charged (USD)	$ Amount Paid (USD)	Receipt contains all required info? *SEE BELOW	Issue payment to:
Choose					☐	MEMBER
Choose					☐	MEMBER
Choose					☐	MEMBER
Choose					☐	MEMBER
Choose					☐	MEMBER

*** In order to process your claim, the following information MUST be included:**

Medical Invoice or receipt:	**Vision receipt:**	**Dental receipt or invoice:**
Provider Name and Tax Identification Date of Service CPT and Diagnosis Code (Procedure Code) Billed Charges and Amount Paid	Provider Name Date of Service CPT(procedure code) Billed Charges and Amount Paid	Provider Name and Tax Identification, Date of Service CPT (procedure code) Diagnosis Code, Billed Charges and Amount Paid

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.

Signature	Date

If there is primary coverage an Explanation of Benefits will be needed for services rendered.

Submission options:

Member can submit for reimbursement by one of the following ways:

1. **Email**:
UMR-QuapawTribalClaims@umr.com

2. **Mail:**
UMR
Attn: Mariah
12668 Silicon Drive
San Antonio, TX 78249