UMR
A UnitedHealthcare Company

COMPASS ROSE HEALTH PLAN

STATESIDE Claim Form: Medical / Dental

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

Fax claims to:
(855) 405-2189

Mail claims to:
UMR
P.O. Box 8095
Wausau, WI 54402-8095

For questions, call:
UMR Customer Service
(888) 438-9135

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)

Primary Member 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) **Is this claim related to an accident?** Yes: ☐ No: ☐

(c) **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 (check all that apply):

Cash register receipts or cancelled checks are not an acceptable claim.

- ☐ Date of Service
- ☐ CPT (procedure) Code
- ☐ Provider Tax Identification Number (TIN)
- ☐ Diagnosis Code
- ☐ Provider Name
- ☐ Billed Charges / Amount Paid

Important: Prescription drug claims should be submitted separately using our Express Scripts Direct Claims Form. For a copy, please visit **www.compassrosebenefits.com/RX**.

Issue payment to: Provider: ☐ Member: ☐

_____ _____

Member's Signature Date