UMR
A UnitedHealthcare Company

COMPASS ROSE HEALTH PLAN

2018 Disputed Claims Form

Name of Health Plan: Compass Rose Health Plan

Group Number: 76-411449

Primary Member Name: _____

Health Plan Member ID#: _____

Patient's Name: _____

Date of Birth: _____ (MM/DD/YYYY)

Claim Control Number: _____

Date of Service: _____ (MM/DD/YYYY)

Provider Name: _____

Total billed amount on claim: _____

Name of individual disputing the claim referenced above: _____

Phone Number: ( ) _____ - _____

Email: _____

Brief description of dispute: _____

_____

_____

Please mail this completed form, along with any supporting medical documents to the following address:

UMR
Attention: Appeals Department
P.O. Box 8095
Wausau, WI 54402-8095

For questions, please call UMR at **(888) 438-9135**.

Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file. This form is to be utilized for initial claims disputes. If you have already received a claims appeal which has been upheld, and do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:
- **90 days** after the date of our letter upholding our initial decision; ***or,***
- **120 days** after you first wrote to us—if we did not respond to that request in some form within 30 days; ***or,***
- **120 days** after we asked for additional information.

For more information on the **disputed claims process**, please refer to the Compass Rose Health Plan 2018 FEHB Plan Brochure (pg 89).