



Group: PM085516

CEBT CLAIM Submission Form

EMPLOYEE INFORMATION

Employee Full Name: _____

Employee Address: _____
Street Address

City State Zip Code

Please check box, is this a new address:

Employee Phone Number: (____)____-____ Employee Date of Birth: ____/____/____

Employee Social Security # or Member ID (from ID Card): _____

PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: ____/____/____

All the above statements are true and complete to the best of my knowledge.

Employee's Signature: _____ Date: _____

Please send this completed claim form, along with the detailed bill from your provider to UMR:

Fax (608) 783-8850

Or Mail to: UMR
PO BOX 826
Onalaska, WI 54650

Please Note: We cannot process a claim from a "balance due" statement. Bills must show patient's name, date (s) of treatment and a description of services and charges. Failure to completely fill out the form may **delay** the payment of your claim. A claim form should be submitted for each member of the family for whom claims are made.