



## **UMR Post-Service Appeal Request Form**

Please fill out the below information when you are requesting a review of an adverse benefit determination or claim denial by UMR.

1.	Today's date:	6. Plan name:
2.	Patient name:	7. Date of service of claim:
3.	Patient date of birth:	8. Claim control number:
4.	Member ID:	9. Total billed amount of claim:
5.	Member name:	10. Provider name:

11. Name of person filling out the form:

Phone number: \_\_\_\_\_

## 12. Description of dispute:

Please fax or mail your completed form along with any supporting medical documentation to the address listed below. Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file.

Fax: 877-291-3248

UMR – Claim Appeals PO Box 30546 Salt Lake City, UT 84130 – 0546