UMR
A UnitedHealthcare Company

COMPASS ROSE HEALTH PLAN

FOREIGN / OVERSEAS Claim Form

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): _____

_____

_____

List the charges that are being claimed. Use a new line for each type of service or provider and attached itemized bills and receipts for ALL services claimed. Use a separate sheet of paper if more space is needed. Translation is required for all foreign documents.
Foreign language (identify country / specify language): _____

Name of Provider Making Charge (as indicated on bill)	Type of Provider (physician: primary/specialist, hospital, dentist)	Description of Service (hospital admission, office visit, lab testing)	Date of Service or Purchase (as reflected on bill)	Charge of Service in Local Currency (provide itemization of charge(s))	Coversion Rate (equal to $1 USD)

For **prescription claims**, please provide a copy of the drug receipt, outlining the pharmacy name, drug, Rx number and date purchased.

Important: Reimbursement will be made through direct deposit by the Claims Payer (UMR) to the member's designated U.S. banking institution. All payments are made is U.S. dollars. Please note that this information will carry over from year-to-year. To discontinue direct deposit, please contact UMR at **(888) 438-9135**.

Name on Bank Account: _____

Bank Name: _____

Bank Routing Number*: _____

Bank Account Number: _____

*MUST be a 9-digit number; starts with 0, 1, 2, or 3 – include all leading zeros & omit any spaces/characters.

Deposit into: Checking Account: ☐ Savings Account: ☐

_____ _____

Member's Signature Date