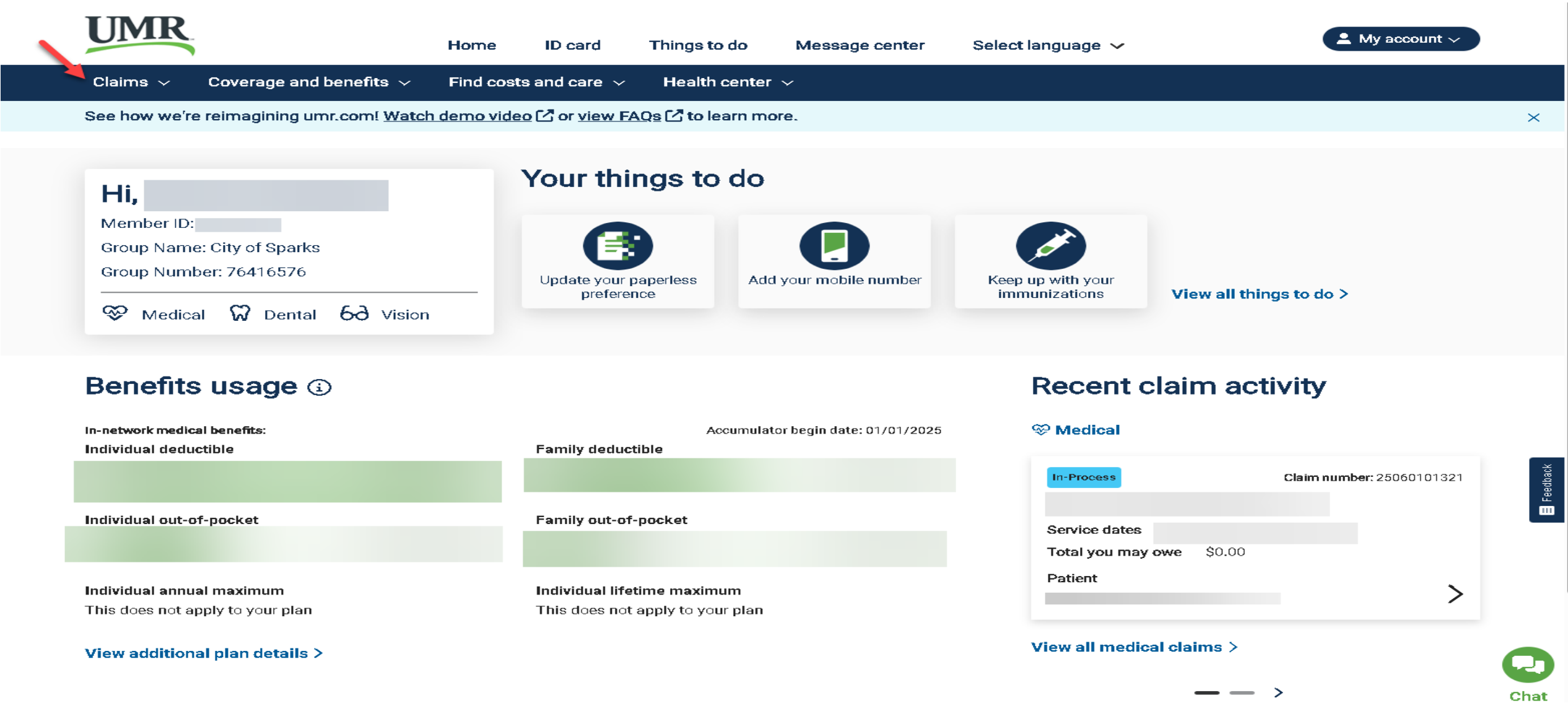
Healthy Lifestyle – Portal upload



Medical
- Medical claims
- Claims cost summary

Dental
- Dental claims
- Claims cost summary

Claim appeals
- Dashboard
- Submit appeal

Other tools
- Submit a claim
- Submit accident details
- Accident details transactions
- Find a form

Group Number: 76416576

Medical | Dental | Vision

Update your paperless preference

Add your mobile number

Keep up with your immunizations

View all things to do >

Benefits usage

In-network medical benefits:

Accumulator begin date: 01/01/2025

Individual deductible

Family deductible

Individual out-of-pocket

Family out-of-pocket

Individual annual maximum
This does not apply to your plan

Individual lifetime maximum
This does not apply to your plan

View additional plan details >

Recent claim activity

Medical

In-Process

Claim number: 25060101321

Service dates

Total you may owe $0.00

Patient

View all medical claims >

Feedback

Chat

Claims

Need to submit a claim?

Submit an online claim 

Use the address below to mail your claims:

CLAIMS:
UMR
PO BOX 211762
EAGAN, MN 55121
Payer ID for electronic claim submission: 39026

UMR
PO Box 30541
Salt Lake City, UT 84130-0541

Our standard timeframe for claims processing is 10 business days, but due to complexity and completeness of the submission, a claim may take up to 30 calendar days to complete. Once your claim is processed, you will receive an explanation of benefits (EOB) statement, or you can check the status of claims and access available EOBs online on the Claims and EOBs page. EOBs are available online within 7-9 days from the date the claim is processed. Claims are only available online for a rolling 24-month period, based on service date.

Submit a claim

Certain pieces of information are required when submitting a claim. Missing key details can delay payment or lead to a claim denial, so be prepared to provide the following:

- Patient name and date of birth
- Facility or provider name, address and tax ID number (TIN)
- Date(s) and type of service (office visit, X-ray, prescription, etc.)
- Description of service as an attachment that includes one or more of the following:
  - Type of service (office visit, injection, etc.)
  - Diagnosis/ICD-10 code (e.g., I10 essential hypertension)
  - Procedure/CPT code (e.g., CPT 99214 Established patient office visit)

You can submit one type of claim (medical, dental, etc.) in a request. To enter multiple types of claims, submit each as a separate request.

Note: If the provider's TIN is not listed on your itemized statement or receipt, contact your provider's office to request the number.

Get started

View submitted claims ›

Employee

Child

Email and phone number

Confirmation of submission will be generated to the email entered. We will contact you at the email or phone number entered above if we have any questions.

Certification*

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies by me or by my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my health plan coverage.
- I have not been reimbursed and will not seek reimbursement for these expenses from any other plan.
- I understand that reimbursement will be made in accordance with the provisions of the plan.
- I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Select this box to certify that details are true and accurate to the best of your knowledge.

Submit a claim

Other insurance

Do you have other insurance?

- ○ Yes
- ◉ No

Payment

Where do you want payment to go?

- ◉ Member
- ○ Provider

Submit a claim

Claim type

You can submit one type of claim in each request.
If you have multiple types of claims, please submit as multiple requests.

What type of claim are you submitting?

Type of claim:*

-Select type of claim-

- -Select type of claim-
- Breast Pump
- COVID-19 Test Kit
- Contraceptive Management
- Dental
- Foreign
- Medical
- Rx Prescription
- Vision
- Wellness

Cancel | Continue

Feedback

Submit a claim

Claim type

You can submit one type of claim in each request.
If you have multiple types of claims, please submit as multiple requests.

What type of claim are you submitting?

Type of claim:*

Wellness

Type of service/product:*

-Select type of service/produ

-Select type of service/product-
Gym Membership
Other
Weight Loss

MM/DD/YYYY

Billed amount($):*

Enter billed amount

+ Add service

You can add multiple services

Claim type

You can submit one type of claim in each request.
If you have multiple types of claims, please submit as multiple requests.

Was the health care service or product provided or purchased outside the United States?

Yes No

Type of claim:*

Wellness

Type of service/product:*

Other

Diagnosis code or short description:*

Enter diagnosis code or short description

Type NA

Service date:* From (mm/dd/yyyy) - To (mm/dd/yyyy)

MM/DD/YYYY to MM/DD/YYYY

Billed amount($):*

Enter billed amount

+ Add service

You can add multiple services

Chat now

Feedback

← Previous

Cancel Continue

Submit a claim

Facility and Provider

Facility

Enter 9 zeros

Tax ID number:*

000000000

Facility name:*

NA

Address 1:*

NA

Address 2: (optional)

City:*

NA

State:*

Nevada

Zip code:*

00000

Provider

Enter 9 zeros

Tax ID number:*

000000000

Provider name:*

NA

Address same as facility? *

(•) Yes ( ) No

← Previous

Cancel | Continue

Submit a claim

Supporting documentation

Supporting documentation must accompany this request form. Please adhere to the following Do's and Don'ts.

Do's

- Include an itemized bill or receipt(s) showing the date(s) of service and type of service with this form.
- Include a copy of the original explanation of benefits (EOB) from your primary insurance carrier, if applicable.
- Scan the documentation on white paper (preferred).
- Upload the receipt containing test kit name and amount paid, if applicable. For example, upload the receipt for COVID-19 home test kits or other at home test kits.

Also, complete and upload the Healthy Lifestyle claim form for each submission

Don'ts

- Do not submit canceled checks or credit card receipts alone. These are not adequate documentation without supporting itemized bill(s) or receipt(s) showing the date(s) of service and type of service.
- Do not submit balance forward statements.
- Do not submit bank statements.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not submit handwritten receipts for prescriptions or over-the-counter items.
- Do not submit pre-treatment estimates or estimated insurance statements.
- Do not submit expenses that have been reimbursed by another plan.

Upload file

Your file should be in .pdf, .png, .jpg or .jpeg format with less than 20 MB size.