

INSTRUCTIONS FOR COMPLETING THIS FORM

Please check with your provider before completing this form. Dental Providers may submit UMR dental claims electronically free of charge from the clearinghouse Optum360:

Email: optum360@optum.com
Phone: 1-866-223-4730
UMR Payer ID: 39026

Sending claims electronically eliminates the need for paper forms and allows for faster and more accurate submission of data.

If your provider has questions regarding this process, they may contact Optum360 or call the UMR EDI unit at 1-800-289-0287.

Below is an explanation to aid in completing the 'Patient Coverage' section of this form.

4. Patient's name
5. Relationship of patient to the employee named in Box 9.
6. Sex of patient
7. Birthdate of patient
8. Name of school and city where located if patient is age 19 or older and a full-time student
9. Employee's name and address
10. Employee's Social Security number
11. Birthdate of employee
12. Name of employee's employer
13. Group number of employee's dental plan
14. Question asking whether the patient has dental coverage through another plan other than the one named in Box 12 and whether the patient has coverage through a group medical plan
- 15-A. Name and address of other dental or medical carrier
- 15-B. Group number of other dental or medical carrier
16. Name and address of employer who provides the other dental or medical coverage
- 17-A. Name of the employee who has the other dental or medical coverage
- 17-B. Social Security number of employee named in Box 17-A
- 17-C. Birthdate of employee named in Box 17-A
18. Relationship of patient to employee named in Box 17-A