# **UMR Group Dental Claim Form**

Document number:

## FRM-SUBS-00877

Applies to: Progress Energy Carolinas, Inc.; Progress Energy Florida, Inc. (non-bargaining employees);

Progress Energy Service Company, LLC

Keywords: human resources information; benefits booklets; HRI-SUBS-00011

The UMR (formerly Fiserv Health) Group Dental Claim Form is administered by UMR. The form is published on the Progress Energy Intranet as received from UMR.

Please check with your provider before completing this form. Your provider may submit claims electronically through Emdeon (formerly Web MD). If your provider has questions regarding this process, he/she may contact Emdeon at 1-888-416-0673 (Payer ID: 39026) or call the UMR EDI unit at 1-800-826-9781.

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

If you have specific questions about filing a claim, call UMR at 1-800-842-6475. If you have general questions, please contact the Employee Service Center at 770-5705 (VoiceNet), 919-546-5705 (Raleigh area), or 1-800-546-5705 (toll-free).

The following link provides access to <u>claim filing instructions and a dental benefits information</u> card.

The following link provides access to the <u>UMR Group Dental Claim Form</u>.

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#### FILING DENTAL CLAIMS

A UMR DENTAL CLAIM FORM YOU CAN PRINT OUT IS ATTACHED. YOU AND YOUR DENTIST MAY COMPLETE THE FORM OR YOU MAY COMPLETE THE EMPLOYEE/PATIENT SECTIONS AND ATTACH AN ITEMIZED BILL FROM YOUR DENTIST. BE SURE ANY AMOUNTS YOU HAVE ALREADY PAID ARE MARKED "PAID."

ALTHOUGH YOU ARE ULTIMATELY RESPONSIBLE FOR ENSURING THAT DENTAL CLAIMS FOR YOURSELF AND YOUR COVERED DEPENDENTS ARE SUBMITTED, SOME DENTAL PROVIDERS MAY OFFER TO SEND CLAIMS DIRECTLY TO UMR. IN THOSE INSTANCES, PROVIDERS MAY COMPLETE THE FORM. AS AN ALTERNATIVE, THEY MAY ALSO SUBMIT THEIR STANDARD, ITEMIZED BILL INSTEAD OF A CLAIM FORM. UMR WILL ALSO ACCEPT ITEMIZED BILLS DIRECTLY FROM DENTAL PROVIDERS AS LONG AS THEY INCLUDE ALL OF THE FOLLOWING INFORMATION:

- PATIENT'S NAME
- **DATE SERVICES WERE RENDERED**
- TYPE OF SERVICE PROVIDED
- **AMOUNT CHARGED FOR EACH SERVICE**

COMPLETED CLAIM FORMS OR ITEMIZED BILLS MUST BE MAILED TO UMR AT THE FOLLOWING ADDRESS:

**UMR** PO Box 30541 SALT LAKE CITY, UT 84130-0541

PROVIDERS MAY ALSO SUBMIT CLAIMS ELECTRONCIALLY. UMR EDI PAYER ID IS 39026.

#### **Dental ID Card**

YOU WILL NOT RECEIVE A DENTAL ID CARD FROM UMR. BEFORE DENTAL SERVICE IS RENDERED, PLEASE INFORM YOUR DENTIST THAT YOU (OR YOUR DEPENDENT) ARE A DENTAL PLAN MEMBER WITH UMR.

IF YOU WISH, YOU MAY COMPLETE AND CUT OUT THE INFORMATION CARD BELOW TO CARRY FOR REFERENCE.

### **DENTAL BENEFITS ADMINISTERED BY**

**UMR** 

For claim questions, call 1-800-842-6475

Group No: 76-140056

**Employer: Progress Energy** Claims should be submitted to:

UMR

PO Box 30541

**SALT LAKE CITY, UT 84130-0541** 

EDI Paver ID 39026

THIS CARD DOES NOT GUARANTEE COVERAGE.

PAYMENT OR ELIGIBILITY.

1.				2.	_					3. Carrier r	name an	d Addr	ess							
Dentist's pre-treatment estimate  Dentist's statement of actual services  Provider ID No.					Medicaid Claim EPSDT Prior Authorization No. Patient ID No.					U	] S	PO BOX 30541 SALT LAKE CITY UT 84130-0541 1-800-842-6475								
P A T	4. Patient name first m.i.		5. Relation to insured  self child spouse other					6. Sex m	f	7. Pai	tient birth M DI				8. If full tim school	e student	city			
I E N T	Employee/subscriber name and mailing address						10. Employee/subscriber soc sec number					11. Employee/subscriber birthdate MM DD YYYY					Energ	7	76-140056	
C O V E R	Is patient covered by another     If yes, complete 15-A.     Is patient covered by a medical	_	an? Ye	브	No N						-B. Group	o No.(s	)	16. N	Name and address of employer					
A G E	17-A. Employee/subscriber name (if different than patient's)						17-B. Employee/subscriber soc. sec. number				11. Employee/subscriber birthdai MM DD YYYY							self child spouse other		
_	19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.								<del>.</del>	I hereby authroize payment of the dental benefits otherwise payable to me directly to the below named dental entity										
B I L	21. Name of Billing Dentist or D	ned (Patient, or parent if minor)  1. Name of Billing Dentist or Dental Entity  2. Address of where payment should be remitted								Signed (Employee/subscriber)  30. Is treatment result of occupational illness or injury?  No Yes If yes, enter brief description and dates of occupational illness or injury?							tes			
L I N G	23. City, State, Zip										32. Other accident?									
E N T I S	Dentist Soc Sec or T.I.N.     First visit date current series	28. Place of treatment 29. Radiographs No Yes Ho												(If no, reason for replacement) 34. Date of prior  placement  If services already Date appliances Mos. treatmen remaining						
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36. I	dentify missing teeth with "X"	Tooth No. or letter	Surface	treatment j		Descri	iption of	Service axis, mate			Da	ate Ser	vice	P	rocedure Number		Fee	<del></del>	For administrative use only	
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4	FACIAL																			
38. I	Remarks for unusual services																			
39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual face. I have charged and intend to callect for those procedures.														tal Fee						
are the actual fees I have charged and intend to collect for those procedures.  License Number									Charged 42. Payment by other plan Max allowable							1				
( Treating Dentist )  Deductible																				
40. Address where treatment was performed  Carrier %																				
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				City				St	ate	Zip				Patient						