Medical Funds Appeal Form

Employer:	Quapaw Tribal Member Plan	Group #:	76-413761
Member:		Member ID#:	
	(Last Name, First Name, Middle Initial)	(Located on Medical ID Card)	
Phone number:		Patient Date of Birth:	
			(mm/dd/yyyy)

Description	
Amount requested	
Use funds from (circle one)	Medical Vision Dental

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.

Signature	Date

Send form and all required supporting documentation(itemized bill from provider) to:

Email: UMR-QuapawAppeals@umr.com

or

Fax: 1-866-898-4878 ATTN: Mariah H.

or

Mail: Vicki Adams c/o Rosa Linda P.

PO BOX 8046

Wausau, WI. 54402