Disputed Claim Form

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): ______________ **Subscriber Name:** ______________________

Phone Number: ______________________ **Email:** ______________________

Claim Control Number: ______________________ **Date of Service (MM/DD/YYYY):** ______________

Provider Name: ______________________ **Total amount billed on claim:** ______________

Name of individual disputing the claim referenced above: ______________________

Today's Date: ______________________

Brief description of dispute: ______________________

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Please mail this completed form, along with any supporting medical documents to the following address:

UMR – CRBG Appeals
Box 8080
Wausau, WI 54402-8080

For questions, please call UMR at **(888) 438-9135**.

Please note: If no medical documentation is submitted, our review will be based on the information we currently have on file. This form is to be utilized for initial claims disputes. If you have already received a claims appeal which has been upheld, and do not agree with our decision, you may ask OPM to review it.

You must write OPM within:

- **90 days** after the date of our letter upholding our initial decision; or,
- **120 days** after you first wrote to us — if we did not respond to that request in some form within 30 days; or,
- **120 days** after we asked for additional information.

For more information on the **disputed claims process**, please refer to Section 8 of the Compass Rose Health Plan FEHB Plan Brochure.