



Claim Form- Natural Family Planning

Please complete the below and email or fax to:

Email: stephanie_j_schmeling@umr.com

Fax: 608-783-8555

St Luke Benefit and Insurance
Services Corp. Group # 76412819

Employee Name: _____

Patient Name: _____

ID#: _____

Natural Family Planning

Date of Service: _____

Billed Amount: \$ _____

Employee Signature _____ Date: _____

This claim form is to be used to seek reimbursement for Natural Family Planning only. Reimbursements will be sent to the employee.

Receipt or Provider signature required.

Receipt attached: _____

Provider name: _____

Provider signature: _____

Please contact UMR-Customer Service at 800-826-9781 if you have any questions.
Thank you.