Transition of Care Request

The employee will need to fill out all information listed in the first, second and third boxes.

Patient Name:
Date of Birth:
Employee Name:
UMR ID#:

Approval for:
Provider Name (Last, First)

Address

Tax Identification Number:
If known

☐ I have verified that this provider is out of network

Patient Diagnosis/ICD9:

Dates of Service: to

UMR will complete this section:
CSR Name:
☐ Approved
☐ Denied

Date:

Denial Reason:

Please return this form to UMR, formerly Fiserv Health, at PO Box 450 Pueblo, CO 81002 or fax the form to 515-697-8045.