UAW RETIREE Medical Benefits Trust

Member Inquiry Form

Updated: May 2019

Please complete all areas of the form below -- do not leave any blanks. If something is not applicable, write "NA" where possible.

Today's Date

Month Day Year

UBR/Counselor Name

Contact Phone

Area Code Phone Number

Contact Email

example@example.com

Would you prefer a response by phone or email?

For the fields below, please provide the member's information unless otherwise indicated.

Auto

Contract Holder

Name

Date of Birth

Month Day Year

Phone Number

Area Code Phone Number

Complete Social Security Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Member Email

Spouse's Name

Spouse's Date of Birth

Month Day Year

Dependent Name (s)

Dependent Eligibility

- ☐ Retirement
- ☐ Surviving Spouse
- ☐ Dependent
- ☐ Death Reporting

Check all that apply and provide details in the section below.

Detail

- ○ Current Health Plan

- ○ MEDICAL CLAIM

Provide the patient's name, date of service, doctor/hospital name, claim amount, a copy of the doctor/hospital bill, and a copy of the explanation of benefits (required).

◯ Drug - Provide Patient's name, date of fill, place of service/mail order, and drug name.

◯ OTHER
Dental, Vision, Physical Therapy, Hospice, etc,

Detail Inquiry

Please save and submit the completed form along with any supporting documentation to: **memberexperience@rhac.com** – if you cannot email this document, please print and complete the form, submitting along with copies of any supporting documentation as follows:

Fax
313-324-5950
Attn: Member Experience

U.S. Mail
UAW Retiree Medical Benefits Trust
Attn: Member Experience
P.O. Box 14309
Detroit, MI 48214