

Out-of-Network Claim Form

Please be aware:

- This entire form must be completed. Incomplete forms will delay payment.
- Complete sections 1-5. Have the doctor who treated you complete the Provider's Statement.
- Sign the "Assignment" portion of Section 5 if you wish to have benefits paid directly to the doctor who treated you.
- The Plan will reimburse covered benefits only. Refer to your Certificate of Coverage for details.
- If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the Explanation of Benefits you received from the other plan.
- If your doctor does not complete the Provider's Statement on the reverse side of this page, you should attach itemized bills.

Section 1: Insurance Information

Insurance Name

Insurance Group ID

Section 2: Policyholder Information

Member Name

Member ID No.

Birthdate

SSN

Street Address

City

State

Zip

Phone number

Section 3: Patient Information

Member Name

Member ID No.

Birthdate

SSN

Street Address

City

State

Zip

Phone number

Gender:

Female

Male

Marital status:

Married

Single

Relationship to employee:

Self

Spouse

Child

Other:

Is patient at full-time student?

Yes

No

Is patient employed?

Yes

No

If yes:

Employer Name

Address of employer

Section 4: Claim Information

Is claim related to employment? Yes No

Is claim related to an accident? Yes No

Date: _____

Time: _____

Describe: _____

Section 5: Release and Assignment

Your healthcare providers are authorized to provide information concerning health care advice, treatment, or supplies provided to you (including that relating to mental illness). This information may be requested by, independent claim administrators, consulting health professionals, and/or utilization review organizations that are contracted to evaluate claims for benefits. May provide the above- named employer with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. I understand that by voluntarily seeking care out of the network, I may be assuming greater financial liability for the care received.

Patient / Authorized Person's Signature Date

Assignment:

I authorize payment of medical benefits to the physician or supplier of service.

Patient / Authorized Person's Signature Date

Provider Statement:

Patient's name: _____ Patient's D.O.B.: _____

Date of illness (first symptom) or injury (accident) or pregnancy (LMP): _____

Date first consulted for this condition: _____

If patient has had similar illness or injury, give date: _____

Was this an emergency? Yes No

Date patient able to return to work: _____

Date of total disability

From: _____ Through: _____

Date of partial disability

From: _____ Through: _____

Name of referring physician (if applicable): _____

For services related to hospitalization, give hospitalization dates:

Admitted: _____ Discharged: _____

Name and address of facility where services were rendered: _____

(if other than home or office)

Diagnosis or nature of illness or injury (indicate primary and secondary)

1. _____

2. _____

3. _____

Procedures, Medical Services, Supplies Furnished

Date of Service		Place of Service*	Procedure Code**	Description of services	Charges	Days / Units	Diagnosis Code***	NPI	Admin Use
From	To								

Physician's Name _____ Physician's Address _____

Federal Tax ID / SSN _____ Telephone Number _____

Patient Account Number _____ Total charge \$ _____
 Amount paid \$ _____
 Balance due \$ _____

* Place of service codes:

- | | | |
|------------------------------------|--|---|
| 11 - Physician office visit | 33 - Custodial care facility | 56 - Psychiatric residential treatment center |
| 12 - Home | 34 - Hospice | 61 - Comprehensive rehab facility, inpatient |
| 21 - Inpatient hospital (med/surg) | 41 - Ambulance, land | 62 - Comprehensive rehab facility, outpatient |
| 22 - Outpatient hospital | 42 - Ambulance, air or water | 65 - End-stage renal treatment facility |
| 23 - Emergency room | 51 - Inpatient psychiatric facility | 71 - State or local public health clinic |
| 24 - Ambulatory surgical facility | 52 - Psychiatric facility, partial hospitalization | 72 - Rural health clinic |
| 25 - Birthing center | 53 - Community mental health center | 81 - Independent laboratory |
| 26 - Military treatment facility | 54 - Intermediate care facility, mentally retarded | 99 - Other, unlisted facility |
| 31 - Skilled nursing facility | 55 - Residential substance abuse facility | |
| 32 - Nursing facility | | |

** Use Current Procedural Terminology Codes (CPT4)

*** Use ICD-10-CM for Diagnosis