

INSTRUCTIONS ON COMPLETING APPLICATION & CHANGE/TERMINATION FORMS

Please type all information

APPLICATION FORM

Please complete the following steps to ensure accuracy for your claim payments:

- 1) Wherever you read “Your company name”, please type the name of the practice or group that receives payment for claims submitted to the UPMC Health Plan;
- 2) Please complete all lines of the application form to ensure proper credit is given to your company;
- 3) On line 3 of the Authorization for Electronic Reimbursements by UPMC Health Plan for Medical Services, the provider number refers to the number for your organization that is located on the top of an EOP document that would accompany your check. If you have multiple numbers, please include all of them.
- 4) Please have form signed by an authorized signer for your company along with their printed name and title.
- 5) Please fax form to 412-454-7744 and mail original to the following address:

UPMC Health Plan
Claims Payable/Accounting
One Chatham Center
112 Washington Place
Suite 600
Pittsburgh, PA 15219

(Please include a voided check with the original documents)

- 6) Please keep a copy for your own records.
- 7) If you have any questions pertaining to the forms discussed, please contact UPMC Health Plan Provider Services at 1-888-876-2756 Monday through Friday from 8:00-5:00.

CHANGE/TERMINATION FORM

Please complete the following steps to ensure accuracy for your claim payments:

- 1) Select one option (either Change or Termination) for this form;
- 2) Enter the “Effective Date for either option;
- 3) Where ever you see “Your Company Name”, please type the name of the practice or group that receives payment for claims submitted to the UPMC Health Plan;
- 4) Please complete all lines marked “prior”;
- 5) On line 5 of the Authorization for Change/Termination, the provider number refers to the number for your organization that is located on the top of an EOP document that would accompany your check. If you have multiple numbers, please include all of them.
- 6) Please complete any new information on the lines marked “new”(If a line does not have any new information, please keep that line blank only);

7) Please have forms signed by an authorized signer for your company along with their printed name and title.

8) Please fax form to 412-454-7744 and mail original to the following address:

UPMC Health Plan
Claims Payable/Accounting
One Chatham Center
112 Washington Place
Suite 600
Pittsburgh, PA 15219

(Please include a voided check with the original documents)

9) Please keep a copy of your request for future needs.

10) If you have any questions pertaining to the forms discussed, please contact UPMC Health Plan Provider Services at 1-888-876-2756 Monday through Friday from 8:00-5:00.

UPMC Health Plan
UPMC Health Benefits, Inc.
UPMC Health Network
UPMC Benefit Management Services, Inc
UPMC Medical Assistance for You

Authorization for Electronic Reimbursement by UPMC Health Plan for Medical Services

If you are interested in receiving electronic payments, please complete the form below

(Your Company Name) hereby (1) authorizes UPMC Health Plan to make payments for services by EFT, (2) certifies that it has selected the following depository institution, and (3) directs that all such Electronic Funds Transfers be made as provided below

Name of Organization: _____

Federal Tax ID Number: _____

Organization's UPMC Provider Number: _____

Depository Institution: _____

Address: _____

Bank Routing Number: _____

Account Number: _____

Account Name: _____

(Your Company Name) acknowledges and agrees that terms and conditions of all agreements with UPMC Health Plan concerning the method and timing of payment for services shall be amended.

(Your Company Name) will give thirty (30) days advance notice in writing to UPMC Health Plan of any changes in its depository institution or other payment instructions.

When properly executed, this Authorization will become effective fifteen (15) days after its receipt by UPMC Health Plan

Dated: _____

(Authorized Signature)

(UPMC Health Plan Authorized Signature)

(Print Name)

(Print Name)

(Title)

(Title)