

## Out-of-Network Care Claim Form

- Both sides of this form must be completed. Incomplete forms will delay payment.
- Complete sections 1-6. Have the doctor who treated you complete the Provider's Statement on the reverse side of this page.
- Sign section 7 if you wish to have benefits paid directly to the doctor who treated you.
- UPMC Health Plan/UPMC Health Benefits will reimburse covered benefits only. Refer to your summary of benefits 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.

**The bills must include:**

- patient's name
- date of service
- charges for each service
- patient's relationship to employee
- type of services rendered
- condition being treated/diagnosis

- UPMC Health Plan/UPMC Health Benefits members should send this completed claim form and itemized bills to:

**UPMC Health Plan/UPMC Health Benefits  
Claims Department  
P.O. Box 2999  
Pittsburgh, PA 15230**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

<b>1. Employer Information</b>	Name _____		Group ID number _____	
<b>2. Employee Information</b>	Social Security number _____	Member ID number _____	Name _____	Birth date _____
	Street address _____		State _____	Zip code _____ Daytime telephone number ( ) _____
<b>3. Patient Information</b>	Social Security number _____	Member ID number _____	Name _____	Birth date _____
	Relationship to employee <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other _____		Address (if different from member) _____	
	Is patient a full-time student? <input type="radio"/> No <input type="radio"/> Yes			
	Sex <input type="radio"/> Male <input type="radio"/> Female	Marital status <input type="radio"/> Married <input type="radio"/> Single	Is patient employed? <input type="radio"/> No <input type="radio"/> Yes	If yes, name and address of employer _____
<b>4. Other Coverage Information</b>	Are any family member's expenses covered by another group health plan, group prepayment plan, no-fault auto insurance, Medicare, or any federal, state, or local government plan? <input type="radio"/> No <input type="radio"/> Yes			
	If yes, list policy or contract holder, policy or contract number(s), and name and address of insurance carrier or administrator. _____			
	Family member's Social Security number _____	Family member's name _____		Family member's birth date _____
<b>5. Claim Information</b>	Is claim related to employment? <input type="radio"/> No <input type="radio"/> Yes		Is claim related to an accident? <input type="radio"/> No <input type="radio"/> Yes If yes, provide Date _____ Time _____ <input type="radio"/> a.m. <input type="radio"/> p.m.	
	If accident, describe. _____			
<b>6. Release</b>	Your health care 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 UPMC Health Plan/UPMC Health Benefits, independent claim administrators, consulting health professionals, and/or utilization review organizations with which UPMC Health Plan/UPMC Health Benefits has contracted to evaluate claims for benefits. UPMC Health Plan/UPMC Health 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's or authorized person's signature _____		Date _____	
<b>7. Assignment</b>	I authorize payment of medical benefits to the physician or supplier of service.			
	Patient's or authorized person's signature _____		Date _____	

# Provider's Statement

## Employee information

To be completed by the treating physician or supplier of service

Name
Social Security number

Patient's name			Patient's birth date
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	If an emergency, check here <input type="radio"/> Emergency
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. | 4. |

### Procedures, Medical Services, Supplies Furnished

Date of service From	To	Place of service*	Procedure code**	Description of service	Type of service @	Charges	Days/units	Diagnosis code +	Administrative use only

Physician's name and address (include zip code)	Telephone number (    )	Federal Tax ID number <input type="radio"/> SSN: ____ - ____ - ____ or <input type="radio"/> EIN: ____ - ____ - ____
	Patient account number	Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____
Physician's or supplier's signature		Date

**\* Place of service codes:**

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

**@ Type of service codes:**

- |                           |  |
|---------------------------|--|
| 1 - Medical care          | 8 - Assistance at surgery                      |
| 2 - Surgery               | 9 - Other medical service                      |
| 3 - Consultation          | 0 - Blood or packed red cells                  |
| 4 - Diagnostic X-ray      | A - Used DME                                   |
| 5 - Diagnostic laboratory | M - Alternate payment for maintenance dialysis |
| 6 - Radiation therapy     | Y - Second opinion on elective surgery         |
| 7 - Anesthesia            | Z - Third opinion on elective surgery          |

**\*\* Use Current Procedural Terminology Codes (CPT4)**

**+ Use ICD-9-CM for diagnosis**