Out-of-Network Care Claim Form

- Complete sections 1-5. Have the doctor who treated you complete the Provider's Statement on the reverse side of this page.
- If your doctor does not complete the Provider's Statement on the second page, please fill it out to the best of your ability and be sure to attach the itemized bill. Incomplete forms may result in a delay in payment.

The itemized bills must include this information:

– Patient's name
– Date of service
– Charges for each service
– Patient's relationship to employee
– Type of services rendered
– Condition being treated/Diagnosis

- In Section 5 please indicate if payment should be made directly to the doctor who treated you, or to the policyholder.
- UPMC Health Plan will reimburse covered benefits only. Refer to your Summary of Benefits for details. Depending on your plan, all applicable copayments, coinsurance, and deductibles may not be reimbursed.
- 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.
- UPMC Health Plan/UPMC Health Benefits members should send this completed claim form, receipts/proof of payment, and itemized bills to:

UPMC Health Plan/UPMC Health Benefits
Claims Department
PO Box 2999
Pittsburgh, PA 15230
or fax to 1-844-201-4655

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 or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

1. Patient Information

Member ID number | Name | Birth date

Relationship to employee

❍ Self ❍ Spouse ❍ Child ❍ Other _____

Is patient a full-time student? ❍ No ❍ Yes

Address (if different from member)

2. Policyholder Information

Member ID number | Name | Birth date

Street address | State | ZIP code | Daytime telephone number

3. Claim Information

Is claim related to employment? ❍ No ❍ Yes

Is claim related to an accident? ❍ No ❍ Yes If yes, provide:

Date _____ Time _____ ❍ a.m. ❍ p.m.

If accident, describe:

4. Release

My health care providers are authorized to provide information and records (including behavioral health information and records) concerning health care treatment related to the claim(s) identified herein to UPMC Health Plan or independent care administrators, consulting health professionals, and utilization review organizations with which UPMC Health Plan has contracted to evaluate claims for benefits. This information will be used to determine eligibility for reimbursement. This authorization is valid upon signature and shall remain valid through the term of the policy or contract under which a claim has been submitted, unless I revoke my consent to the authorization by written request to UPMC Health Plan. I acknowledge that revoking this authorization may impact UPMC Health Plan's ability to determine eligibility for reimbursement. I know that I have a right to receive a copy of this authorization upon request. I understand that by voluntarily seeking care out of the network, I may be assuming greater financial liability for the care received.

I have read and fully understand the terms of this release.

Patient's or authorized person's signature_____ Date_____

5. Payment Authorization

I authorize payment of medical benefits to the party indicated in the check box below:

❍ Provider Payment ❍ Policyholder Payment (Me)

Patient's or authorized person's signature _____ Date _____

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Contact us at 1-844-201-4674. TTY: 711. Fax: 1-844-201-4655.

Hours of Operation for Direct Member Reimbursement are 9:00 AM to 3:30 PM, Monday through Friday.

Provider's Statement

To be completed by the treating physician or supplier of service

Employee Information

Name

Patient's name	Member ID	Patient's birth date
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)

If treatment was received outside of the United States, please list the country where services were rendered

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

1. 2.

3. 4.

Procedures, Medical Services, Supplies Furnished

Date of service		Place of service	Procedure code	Description of service	Charges	Days/Units	Diagnosis code	NPI
From	To							

Physician's name and address (include ZIP code)	Telephone number	Federal tax ID number
		❍ NPI:
	Patient account number	Total charge $ Amount paid $ Balance due $
Physician's or supplier's signature		Date

For Payment Outside the United States

Account name: _____ Account number: _____

Sort code: _____ Swift code: _____ IBAN code: _____

Bank name: _____ Bank address: _____

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