UPMC HEALTH PLAN

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 will reimburse eligible expenses 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.

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.

- 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
  - patient's relationship to employee
  - date of service
  - type of services rendered
  - charges for each service
  - condition being treated
- Send this completed claim form and itemized bills to:

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

1. Employer Information

Name	Group ID number

2. Employee Information

Social Security number	Member ID number	Name	Birth date

Street address	State	Zip Code	Daytime telephone number
			( )

3. Patient Information

Social Security number	Member ID number	Name	Birth date

Relationship to participant

O Self O Spouse O Child O Other_____

Address (if different from member)

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

Sex	Marital status	Is patient employed?	If yes, name and address of employer
O Male O Female	O Married O Single	O No O Yes	

4. Other Coverage Information

Are any family members' expenses covered by another group health plan, group pre-payment plan, no-fault auto insurance, Medicare, or any federal, state, or local government plan?

O No O Yes

If yes, list policy or contract holder, policy or contract number(s), and name/address of insurance or administrator.

Family member's Social Security number	Family member's name	Family member's birth date

5. Claim Information

Is claim related to employment?

O No O Yes

Is claim related to an accident?

O No O Yes If yes, Date_____ Time _____ O am O pm

If accident, describe.

Were the services referred by your PCP? O No O Yes **If yes, attach copy of referral form.**
(check "no" if you do not have a PCP)

6. Release

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, independent claim administrators, consulting health professionals, and/or utilization review organizations with which UPMC Health Plan has contracted to evaluate claims for benefits. UPMC Health Plan 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 _____

7. Assignment

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

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

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Provider's Statement

To be completed by the treating physician or supplier of service

Employee information

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

❍ 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 & address of facility where services 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 & address (include Zip Code)

Telephone number

( )

Federal Tax ID Number

☐SSN: _____ - _____ - _____

or

☐EIN: _____ - _____ - _____

Patient account number

Total charge $_____

Amount paid $_____

Balance due $_____

Physician's or supplier's signature

Date

*** Place of service codes:**

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

@ Type of service codes:

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

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

+ Use ICD-9-CM for diagnosis