UPMC HEALTH PLAN

Out-of-Network Care Claim Form

- Both sides of this form must be completed. Incomplete forms will delay payment.
- Complete sections 1-5. 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 reverse side of this page, please attach itemized bills.

The itemized bills must include:

– Patient's name
– Date of service
– Charges for each service
– Patient's relationship to policy holder
– Type of services rendered
– Condition being treated/diagnosis
– Provider federal tax ID

- In Section 5, please indicate if payment should be made directly to the doctor who treated you or to the policy holder.

  If you are requesting reimbursement to the policy holder, any missing information such as provider information, provider federal tax ID, diagnosis, procedure code, or proof of payment will result in a claim denial.

- UPMC Health Plan/UPMC Health Benefits 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 412-454-8519

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.

1. Patient Information

Member ID number | Name | Birth date / /

Relationship to policy holder
❍ Self ❍ Spouse ❍ Child ❍ Other _____

Address (if different from policy holder)

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

Sex ❍ Male ❍ Female | Marital status ❍ Married ❍ Single

2. Policy Holder 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

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 _____

5. Assignment

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

❍ Provider Payment ❍ Policy Holder Payment

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

Provider's Statement

To be completed by the treating physician or supplier of service

Patient 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 ❍ 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: _____