UPMC HEALTH PLAN

SUBSCRIBER SUBMITTED CLAIM FORM

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.

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 employee

❍ Self ❍ Spouse ❍ Child ❍ Other _____

Address (if different from member)

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

Sex

❍ Male ❍ Female

Marital status

❍ Married ❍ Single

Is patient employed?

❍ No ❍ Yes

If yes, name and address of employer

4. Other Coverage Information

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? ❍ No ❍ 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

5. 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.

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/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 _____

7. Assignment

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

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

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 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		Place of service*	Procedure code**	Description of service	Charges	Days/units	Diagnosis code†	NPI	Administrative use only
From	To								

Physician's name and 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:**

11 - Physician office visit
12 - 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

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

†Use ICD-9-CM for diagnosis