

## 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.**

<b>1. Patient Information</b>	Member ID number	Name		Birth date / /		
	Relationship to policy holder <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other _____			Address (if different from policy holder)		
	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				
<b>2. Policy Holder Information</b>	Member ID number	Name		Birth date / /		
	Street address		State	ZIP code	Daytime telephone number - -	
	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.		
<b>3. Claim Information</b>	If accident, describe.					
	<b>4. 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>5. Assignment</b>	I authorize payment of medical benefits to the party indicated in the check box below:					
	<input type="radio"/> Provider Payment <input checked="" type="radio"/> Policy Holder Payment					
Patient's or authorized person's signature _____ Date _____						

