

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
- Patient's relationship to employee
- Date of service
- Type of services rendered
- Charges for each service
- 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 <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other _____		Address (if different from member)
Is patient a full-time student? <input type="radio"/> No <input type="radio"/> Yes		

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? <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.
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.

