Out-of-Plan Reimbursement Form

(Please print or type)

1. MEMBER'S NAME
   Last _____ First Name _____ Middle Name Initial _____

2. MEMBER ID # (See ID card) _____

3. MEMBER'S ADDRESS

   No., Street _____ City _____ State _____ ZIP _____

4. TELEPHONE NUMBER
   ( ) _ _ _ - _ _ _ _

5. MEMBER'S BIRTHDATE
   MM DD YY

SEX
❑ Male ❑ Female

6. IS MEMBER'S CONDITION RELATED TO:
   Accident at Work? ❑ Yes ❑ No
   Auto Accident? ❑ Yes ❑ No
   Other Accident? ❑ Yes ❑ No
   Illness? ❑ Yes ❑ No

7. IS MEMBER'S COVERED UNDER ANOTHER HEALTH BENEFIT PLAN?
   ❑ Yes ❑ No (If no, skip item 8 a-d)

OTHER INSURANCE INFORMATION (To be answered only if you answered yes to item 7)

8. OTHER INSURED'S NAME (See ID Card _____

a. OTHER INSURED'S POLICY OR GROUP INFORMATION

   Group # _____ Patient ID # _____

   Insurance Co. Name _____

b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY)_____ SEX ❑ Male ❑ Female

c. OTHER INSURED'S EMPLOYER'S NAME _____

d. INSURANCE PLAN NAME OR PROGRAM NAME _____

9. SHOULD PAYMENT BE MADE TO: SELF ❑ Yes ❑ No
   PROVIDER ❑ Yes ❑ No (If yes, please sign item 10)

PLEASE SIGN IF PROVIDER SHOULD RECEIVE PAYMENT FOR SERVICES

10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
    I authorize payment of medical benefits to the physician or supplier indicated on the attached original itemized bill for services.

SIGNED _____

READ INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM.

11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I certify that the information provided is correct to the best of my knowledge and belief.

SIGNED _____ DATE _____

12. ADDITIONAL INFORMATION OR COMMENTS:

ConnectiCare

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Out-of-Plan Reimbursement Form Instructions

(Please print or type)

Use this form:

- If you are seeking reimbursement for a medical service that you paid out of your own pocket.
- If you are requesting payment to be made to an out out-of-plan or non-participating provider from which you received a medical service.
- If you are requesting coordination of benefits with your primary insurance company.
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-224-2273 (TTY: 1-800-842-9710).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-224-2273 (TTY: 1-800-842-9710).

1. You must enclose the original itemized bill from your provider. An itemized bill includes the following information: date of service, diagnosis (cause and nature of person's illness), procedure code (description of the procedure), charges and payments made: and the provider's full name, address, phone number, provider tax ID number, and/or National Provider Identifier (NPI).
    - A balance due statement from your provider is not acceptable and your claim cannot be processed.
    - If services were rendered outside of the United States, please provide an itemized bill written in English which shows the paid in U.S. dollars.
    - If coordination of benefits is being sought, attach a copy of the primary carrier's Explanation of Benefits along with the itemized bill.
    - To expedite payment of your claim, please be sure that your provider's tax ID number is on the itemized bill. If the tax ID number is not on the bill, please obtain the number and write it on the bill you are enclosing.
2. Complete the entire form on the reverse side.
    - Please use one claim form for each claim you are submitting.
3. Mail the complete form and attachments indicated above to:

Medical and Surgical Claims
ConnectiCare Claims Department
P. O. Box 4000
Farmington, CT 06034-4000

Mental Health and Substance Abuse Claims
Optum Health Behavioral Solutions
P. O. Box 30757
Salt Lake City, UT 84130-0757

Retain a copy of your claim submission for your own records.

ConnectiCare

www.connecticare.com/medicare