Out-of-Network Provider Claim Form

Please complete all sections. Incomplete forms may delay processing.

1. Patient Information

First Name

Last Name

Date of Birth

Member ID Number

Phone Number

Address

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2. Provider Information

Provider Name

NPI Number

Provider Address

Phone

Tax ID

Specialty

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3. Service Information

Diagnosis/ICD Code(s)

Date of Service	Procedure Code	Description	Charge Amount	Units

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4. Additional Details

Was the service related to an accident?

Select

If yes, please describe

5. Submission Checklist

- Completed claim form
- Itemized bill from provider
- Proof of payment (if applicable)
- Copy of insurance card

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6. Signature

Signature

Date