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-of-plan or nonparticipating provider from which you received a medical service.
- If you are requesting coordination of benefits with your primary insurance company.
- 1. You must enclose the original itemized bill from your provider. An itemized bill must include the following information: date of service, diagnosis (cause and nature of a person's illness), procedure code (description of the procedure), place of service (office visit, hospital, ambulatory surgery center, etc.) charges and payments made; and the provider's full name, address, phone number and provider tax ID number/and or National Provider Identifier (NPI).
 - A balance due statement from your provider is not acceptable and your claim <u>cannot</u> be processed.
 - If services were rendered outside of the United States, please provide an itemized bill written in English which shows the amount 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 providers 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 546
Farmington, CT 06034-0546

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

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



175 Scott Swamp Road • P.O. Box 4050 • Farmington, CT • 06034-4050 • www.connecticare.com

Coverage is provided by and services are administered as follows: In Connecticut: Group HMO and POS coverage, and Individual HMO is underwritten by ConnectiCare, Inc.; Individual POS is underwritten by ConnectiCare Insurance Company, Inc. In Massachusetts: Group HMO and POS coverage is underwritten by ConnectiCare of Massachusetts, Inc. In New York: HMO and POS is underwritten by ConnectiCare of New York, Inc. FlexPOS, ASO/Self-funded services, and Dental products are administered or underwritten by ConnectiCare Insurance Company, Inc.

Out-of-Plan Reimbursement Form

(Please print or type)

PATIENT'S NAME (Last Name, First Name, Middle Initial)	2. PATIENT'S ID #	3. PATIENT'S ADDRESS
4. PATIENT'S STATUS		No., Street
	red □ Full-Time Student □ Part-Time Student	City State
5. PATIENT'S BIRTHDATE	6. PATIENT'S RELATIONSHIP TO INSURED	()
MM DD YY SEX □ Male □ Female	□ Self □ Spouse □ Child □ Other	ZIP Telephone Number
7. IS PATIENT'S CONDITION RELATED TO:	8. INSURED'S NAME (Last Name, First Name, Middle Initial)	10. INSURED'S GROUP NUMBER/GROUP NAME (See ID Card)
ACCIDENT AT WORK? ☐ Yes ☐ No		a. INSURED'S ID NUMBER (SEE ID CARD)
AUTO ACCIDENT? ☐ Yes ☐ No		b. IS INSURED COVERED UNDER
OTHER ACCIDENT?	9. INSURED'S ADDRESS	ANOTHER HEALTH BENEFIT PLAN?
ILLNESS?	No., Street	☐ Yes ☐ No
DID CONDITION OCCUR WHILE?		If yes, complete item 11 a-d
☐ ON VACATION	City State	c. INSURED'S DATE OF BIRTH
☐ AWAY AT SCHOOL	ZIP () ZIP Telephone Number	MM DD YY SEX
OTHER		☐ Male ☐ Female
	12. SHOULD PAYMENT BE MADE TO:	13. DESCRIBE CONDITION OR ILLNESS:
OTHER INSURANCE INFORMATION (To be completed only if you answered yes to item 10b)	SELF	
11. OTHER INSURED'S NAME (See ID Card)	PROVIDER	
	If yes, please sign item #14	WHERE WERE SERVICES RENDERED?
a. OTHER INSURED'S POLICY OR GROUP INFORMATION		☐ Urgent Care Ctr ☐ Hospital ☐ Office
Group # Patient ID#	DUFACE CICAL IE DECLUEDE CHOULD DECENT	COUNTRY COUNTRY
Insurance Co. Name	PLEASE SIGN IF PROVIDER SHOULD RECEIVE	
b. O'THER INSURED'S DATE OF BIRTH	14. INSURED'S OR AUTHORIZED PERSON'S SI I authorize payment of medical benefits to attached original itemized bill for services.	
Male ☐ Female	SIGNED	
c. EMPLOYER'S NAME OR SCHOOL NAME	READ INSTRUCTIONS BEFORE COMPLETING & SIGNING THIS FORM.	
IVAIVIE	15. PATIENT'S OR AUTHORIZED PERSON'S S	
d. INSURANCE PLAN NAME OR PROGRAM NAME	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. Any person who, knowingly and with intent to defraud any MCO or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of committing a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation. If you suspect fraud, call ConnectiCare's Special Investigative Unit at 1-800-349-2833.	
	SIGNED	DATE

