

# 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 cannot 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  
United Behavioral Health  
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](http://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, PPO, 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)

1. PATIENT'S NAME (Last Name, First Name, Middle Initial)		2. PATIENT'S ID #		3. PATIENT'S ADDRESS	
4. PATIENT'S STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student				No., Street	
5. PATIENT'S BIRTHDATE MM DD YY                      SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		6. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		City _____ State _____	
7. IS PATIENT'S CONDITION RELATED TO:  ACCIDENT AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No  AUTO ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No  OTHER ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No  ILLNESS? <input type="checkbox"/> Yes <input type="checkbox"/> No  DID CONDITION OCCUR WHILE? <input type="checkbox"/> ON VACATION <input type="checkbox"/> AWAY AT SCHOOL <input type="checkbox"/> OTHER _____		8. INSURED'S NAME (Last Name, First Name, Middle Initial)		10. INSURED'S GROUP NUMBER/GROUP NAME (See ID Card)	
		9. INSURED'S ADDRESS		a. INSURED'S ID NUMBER (SEE ID CARD)	
		No., Street _____			
		City _____ State _____		b. IS INSURED COVERED UNDER ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		ZIP _____ Telephone Number _____		If yes, complete item 11 a-d	
		12. SHOULD PAYMENT BE MADE TO:  SELF <input type="checkbox"/> Yes <input type="checkbox"/> No  PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, please sign item #13		c. INSURED'S DATE OF BIRTH  MM DD YY                      SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b><u>OTHER INSURANCE INFORMATION</u></b> (To be completed only if you answered yes to item 10b)		PLEASE SIGN IF PROVIDER SHOULD RECEIVE PAYMENT FOR SERVICES			
11. OTHER INSURED'S NAME (See ID Card)		13. 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.			
a. OTHER INSURED'S POLICY OR GROUP INFORMATION Group # _____ Patient ID# _____ Insurance Co. Name _____		SIGNED _____			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY                      SEX <input type="checkbox"/> Male <input type="checkbox"/> Female					
c. EMPLOYER'S NAME OR SCHOOL NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME					
				<b><i>READ INSTRUCTIONS BEFORE COMPLETING &amp; SIGNING THIS FORM.</i></b>	
				14. 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. 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 _____	

