Out-of-Plan Reimbursement Form Instructions

(Please print or type)

Use this form:

- If you are seeking reimbursement for a medical service that you received within the last 6 months (180 days) and paid for 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
OptumHealth Behavioral Solutions
P.O. Box 30757
Salt Lake City, UT 84130-0757

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

ConnectiCare®

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

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

No., Street

City State

ZIP Telephone Number

4. PATIENT'S STATUS

☐ Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

5. PATIENT'S BIRTHDATE

MM DD YY SEX ☐ Male ☐ Female

6. PATIENT'S RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Child ☐ Other

7. IS PATIENT'S CONDITION RELATED TO:

ACCIDENT AT WORK? ☐ Yes ☐ No

AUTO ACCIDENT? ☐ Yes ☐ No

OTHER ACCIDENT? ☐ Yes ☐ No

ILLNESS? ☐ Yes ☐ No

DID CONDITION OCCUR WHILE?

☐ ON VACATION

☐ AWAY AT SCHOOL

☐ OTHER _____

_____

8. INSURED'S NAME
(Last Name, First Name, Middle Initial)

9. INSURED'S ADDRESS

No., Street

City State

ZIP Telephone Number

10. INSURED'S GROUP NUMBER/GROUP NAME (See ID Card)

a. INSURED'S ID NUMBER (SEE ID CARD)

b. IS INSURED COVERED UNDER ANOTHER HEALTH BENEFIT PLAN?

☐ Yes ☐ No

If yes, complete item 11 a-d

c. INSURED'S DATE OF BIRTH

MM DD YY SEX ☐ Male ☐ Female

OTHER INSURANCE INFORMATION

(To be completed only if you answered yes to item 10b)

11. 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. EMPLOYER'S NAME OR SCHOOL NAME

_____

_____

d. INSURANCE PLAN NAME OR PROGRAM NAME

_____

_____

12. SHOULD PAYMENT BE MADE TO:

SELF ☐ Yes ☐ No

PROVIDER ☐ Yes ☐ No

If yes, please sign item #14

13. DESCRIBE CONDITION OR ILLNESS:

_____

_____

WHERE WERE SERVICES RENDERED?

☐ Urgent Care Ctr ☐ Hospital ☐ Office

_____ COUNTRY

PLEASE SIGN IF PROVIDER SHOULD RECEIVE PAYMENT FOR SERVICES

14. 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 & SIGNING THIS FORM.

15. 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 _____

ConnectiCare

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

ConnectiCare

Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 1-800-833-8134. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Continued →

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-800-251-7722 (TTY: 1-800-833-8134).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-251-7722 (TTY: 1-800-833-8134).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-800-251-7722 (TTY: 1-800-833-8134).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 1-800-833-8134）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-800-251-7722 (TTY: 1-800-833-8134).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-800-251-7722 (ATS: 1-800-833-8134).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-251-7722 (TTY: 1-800-833-8134).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-251-7722 (телетайп: 1-800-833-8134).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-251-7722 (TTY: 1-800-833-8134).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 1-800-833-8134).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-251-7722 (TTY: 1-800-833-8134)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-800-251-7722 (TTY: 1-800-833-8134).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-800-251-7722 (TTY: 1-800-833-8134) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 1-800-833-8134).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 1-800-833-8134).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។
ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 1-800-833-8134)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-251-7722 (TTY: 1-800-833-8134).