Medical Claim Pre-Estimate Form

Instructions

- *Complete all fields on form and sent to ConnectiCare Inc, 175 Scott Swamp Rd, Farmington, CT 06032, ATT: Claims Pre-Estimate or Fax form to (860) 409-2455*
- *All incomplete forms will be returned*

Patient / Insured Information

PATIENT'S I.D. NUMBER	INSURED'S NAME (Last Name, First Name, Middle Initial)
INSURED'S ADDRESS	PATIENT'S RELATIONSHIP TO INSURED Self ❑ Spouse ❑ Child ❑ Other ❑
PATIENT'S NAME (Last Name, First Name, Middle Initial	PATIENTS DATE OF BIRTH / / MM DD YY SEX M ❑ F ❑

Provider Information

PHYSICIAN'S FULL NAME	PHYSICIAN'S FEDERAL TAX ID NUMBER
PHYSICIAN'S ADDRESS	PHYSICIAN'S NPI #

Medical Service Information

PLACE OF SERVICE	PROCEDURE (CPT/HCPCS CODE)	MODIFIER	DIAGNOSIS CODE	CHARGE	DAYS OR UNITS

Pre-Estimate Response information

PLEASE SELECT BELOW, HOW YOU WOULD LIKE TO RECEIVE YOUR PRE-ESTIMATE RESPONSE.

❑ **US MAIL** - PLEASE MAIL MY MEDICAL PRE-ESTIMATE TO _____

❑ **E-MAIL** - PLEASE EMAIL MY MEDICAL PRE-ESTIMATE TO _____

❑ **FAX** - PLEASE FAX MY MEDICAL PRE-ESTIMATE TO _____

** Please note:*

- *The cost information you will receive is a good faith estimate only and is not legally binding on ConnectiCare, Inc.*
- *This is a pre-estimate only and does not include any other services provided by other physicians or facilities (including but not limited to radiologist, pathologists, and anesthesiologists.*
- *The accuracy of the estimate that we provide you will depend largely on the specificity and accuracy of the information you provide to us regarding your proposed medical service.*