Together with CCHP
PO Box 106013 | Pittsburgh, PA 15230-6013
Toll-free: 1-844-201-4672 | togetherCCHP.org

Out-of-Network Claim Form

Please be aware:

- This entire form must be completed. Incomplete forms will delay payment.
- Complete sections 1-5. Have the doctor who treated you complete the Provider's Statement.
- Sign the "Assignment" portion of Section 5 if you wish to have benefits paid directly to the doctor who treated you.
- The Plan will reimburse covered benefits only. Refer to your Certificate of Coverage for details.
- If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the Explanation of Benefits you received from the other plan.
- If your doctor does not complete the Provider's Statement on the reverse side of this page, you should attach itemized bills.

Section 1: Insurance Information

Insurance Name _____ Insurance Group ID _____

Section 2: Policyholder Information

Member Name _____ Member ID No. _____ Birthdate _____ SSN _____

Street Address _____ City _____ State _____ Zip _____ Phone number _____

Section 3: Patient Information

Member Name _____ Member ID No. _____ Birthdate _____ SSN _____

Street Address _____ City _____ State _____ Zip _____ Phone number _____

Gender: ☐ Female ☐ Male
Marital status: ☐ Married ☐ Single

Relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Is patient at full-time student? ☐ Yes ☐ No
Is patient employed? ☐ Yes ☐ No
If yes:

Employer Name _____ Address of employer _____

Internal Reference: TOG Member Form – OON Claim Form (2019.0917)

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Section 4: Claim Information

Is claim related to employment? ☐ Yes ☐ No

Is claim related to an accident? ☐ Yes ☐ No

Date: _____

Time: _____

Describe: _____

_____

Section 5: Release and Assignment

Your healthcare providers are authorized to provide information concerning health care advice, treatment, or supplies provided to you (including that relating to mental illness). This information may be requested by, independent claim administrators, consulting health professionals, and/or utilization review organizations that are contracted to evaluate claims for benefits. May provide the above- named employer with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. I understand that by voluntarily seeking care out of the network, I may be assuming greater financial liability for the care received.

_____ _____

Patient / Authorized Person's Signature Date

Assignment:

I authorize payment of medical benefits to the physician or supplier of service.

_____ _____

Patient / Authorized Person's Signature Date

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Provider Statement:

Patient's name: _____ Patient's D.O.B.: _____

Date of illness (first symptom) or injury (accident) or pregnancy (LMP): _____

Date first consulted for this condition: _____

If patient has had similar illness or injury, give date: _____

Was this an emergency? ☐ Yes ☐ No

Date patient able to return to work: _____

Date of total disability

From: _____ Through: _____

Date of partial disability

From: _____ Through: _____

Name of referring physician (if applicable): _____

For services related to hospitalization, give hospitalization dates:

Admitted: _____ Discharged: _____

Name and address of facility where services were rendered: _____

(if other than home or office)

Diagnosis or nature of illness or injury (indicate primary and secondary)

1. _____

_____

2. _____

_____

3. _____

_____

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Procedures, Medical Services, Supplies Furnished

Date of Service		Place of Service*	Procedure Code**	Description of services	Charges	Days / Units	Diagnosis Code***	NPI	Admin Use
From	To								

Physician's Name

Physician's Address

Federal Tax ID / SSN

Telephone Number

Patient Account Number

Total charge $

Amount paid $

Balance due $

* Place of service codes:

11 - Physician office visit
12 - Home
21 - Inpatient hospital (med/surg)
22 - Outpatient hospital
23 - Emergency room
24 - Ambulatory surgical facility
25 - Birthing center
26 - Military treatment facility
31 - Skilled nursing facility
32 - Nursing facility
33 - Custodial care facility
34 - Hospice
41 - Ambulance, land
42 - Ambulance, air or water
51 - Inpatient psychiatric facility
52 - Psychiatric facility, partial hospitalization
53 - Community mental health center
54 - Intermediate care facility, mentally retarded
55 - Residential substance abuse facility
56 - Psychiatric residential treatment center
61 - Comprehensive rehab facility, inpatient
62 - Comprehensive rehab facility, outpatient
65 - End-stage renal treatment facility
71 - State or local public health clinic
72 - Rural health clinic
81 - Independent laboratory
99 - Other, unlisted facility

** Use Current Procedural Terminology Codes (CPT4)
*** Use ICD-10-CM for Diagnosis