

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
OptumHealth Behavioral Solutions
P.O. Box 30757
Salt Lake City, UT 84130-0757

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

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You know us by 

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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.

F005 03/10

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		b. IS INSURED COVERED UNDER ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete item 11 a-d
		City State		c. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
		ZIP Telephone Number		
11. OTHER INSURED'S NAME (See ID Card)		12. SHOULD PAYMENT BE MADE TO:		13. DESCRIBE CONDITION OR ILLNESS:
a. OTHER INSURED'S POLICY OR GROUP INFORMATION Group # _____ Patient ID# _____ Insurance Co. Name _____		SELF <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		PROVIDER <input type="checkbox"/> Yes <input type="checkbox"/> No		WHERE WERE SERVICES RENDERED? <input type="checkbox"/> Urgent Care Ctr <input type="checkbox"/> Hospital <input type="checkbox"/> Office _____ COUNTRY
c. EMPLOYER'S NAME OR SCHOOL NAME		If yes, please sign item #14		
d. INSURANCE PLAN NAME OR PROGRAM NAME		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 _____		
		<p align="center">READ INSTRUCTIONS BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p>		
		SIGNED _____ DATE _____		



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F005 03/10