HEALTHYCT
YOUR HEALTH – YOUR PLAN.

Out-of-Network Claim Submission

Complete this form to submit a claim for an out-of-network medical service. You can receive payment for a medical service you already paid or request that payment be made directly to your provider. Please complete one form for each provider that treated you. Be sure to print legibly and, preferably, in black ink.

Please be sure to send an itemized bill with the following information. We can't accept just a balance due statement or payment receipt because they don't have the information we need to process your claim.

- Date of service
- Diagnosis (including the cause and nature of the patient's condition)
- Procedure code
- Location of service (doctor's office, hospital, urgent care facility, etc.)
- Billed charges
- Proof of payment made
- Provider's full name, address and phone number
- Provider's tax identification number and/or National Provider Identifier (NPI)

If you received services outside of the United States, include:

- A copy of your original itemized bill showing the total charges for the services you received
- If you have an itemized bill translated into English and showing the charges in US dollars, please include that as well
- If you paid by credit card, please include a copy of the receipt

If you have other coverage that paid part of your bill, include:

- A copy of the Explanation of Benefits from your primary insurance company

Mail your completed claim form, itemized bill, payment receipt and Explanation of Benefits from your primary insurance company (if applicable) to:

HealthyCT
P.O. Box 33728
Indianapolis, IN 46203-0728

If you have questions, please call Member Services at the number on your ID card.

Please keep a copy of all documents you send to us for your records.

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A photocopy version of this form is as valid as the original

Send your completed form to: HealthyCT, P.O. Box 33728, Indianapolis, IN 46203-0728

HealthyCT Subscriber Name (First Name, Middle Initial, Last Name)		Subscriber's Date of Birth	Sex □ M □ F
Address 1	Address 2	City, State Zip	
Phone	Subscriber's HealthyCT ID#		
Patient's Name (First Name, Middle Initial, Last Name) (if different from Subscriber)		Patient's Date of Birth	Sex □ M □ F
Address 1	Address 2	City, State Zip	
Phone	Subscriber's HealthyCT ID#		
Patient's Relationship to Subscriber □ Self □ Spouse □ Child □ Other	Patient's Status □ Single □ Married □ Other □ Employed □ Full-time Student □ Part-time Student		

Is Patient Covered Under Another Benefit Plan? □ Yes □ No

If Yes, please include a copy of your primary insurance company's Explanation of Benefits and complete the following information. If No, please move on to the next section.

Other Insurance Company Name	Other Insurance Company ID#	
Policyholder's Name (if different from above)	Policyholder's Date of Birth	Policyholder's Sex □ M □ F

Is Condition Requiring Treatment Caused by a(n): □ Work Accident □ Auto Accident □ Other Accident □ Injury □ Illness

When Did the Condition Happen?	Where Did the Condition Happen?
Describe Condition Requiring Treatment:	Where Were Services Rendered? □ Hospital □ Urgent Care Center □ Doctor's Office □ Other In What Country?

Please send payment to: □ Myself □ My provider

Sign below if you would like us to send payment directly to your provider:

I authorize payment of benefits to the physician or provider indicated on the enclosed itemized bill. I acknowledge that I am responsible for any additional charges in excess of the plan's payment schedule or not covered by my benefit plan.

Subscriber's Signature Date

We can't process your claim unless you sign below:

I attest to the above information in this form as accurate, true and complete. I authorize all medical professionals, hospitals, and other facilities, payers, employers and group policyholders, contract holders or benefit plan administrators to provide HealthyCT or any consumer reporting agencies, attorneys and independent claim administrators acting on HealthyCT's behalf, with information concerning medical care, advice, treatment or supplies provided to the patient, and any employment-related information regarding the patient. This information will be used to evaluate and administer claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted, and that I have a right to receive a copy of this authorization upon request.

Subscriber's Signature Date