MEDICAL PRETREATMENT ESTIMATE FORM

Public Employees Local 71 Trust Fund

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Use this form to have your doctor provide an estimate for medical treatment costs expected to exceed $1,000.00 prior to receiving services.

PLEASE PRINT CLEARLY

Employee name: SSN or Alternate ID:

Patient name: Date of birth:

Date of proposed treatment:

General description of proposed treatment (please submit additional documentation supporting medical necessity if appropriate):

Description of Service: CPT Code:

Estimated Price: $

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Estimated Price: $

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Estimated Price: $

CERTIFICATION

The above is our best estimate of the services to be provided (and not a guarantee of payment). The cost of services is based on current pricing. The scope of services may change based upon the patient's needs at the time of treatment.

I understand that this patient's preferred provider (PPO) for inpatient and outpatient hospital services (including labs, X-rays, scans and other ancillary services) within the Municipality of Anchorage is Alaska Regional Hospital. The preferred providers for physical therapy are Chugach Physical Therapy, Ascension Physical Therapy and Alaska Hand Rehabilitation. Participants will be responsible for significant additional costs if a non-PPO provider is used within the Municipality of Anchorage. For all other services (inside or outside Alaska), participants are encouraged to use the Beech Street network of providers to receive the benefit of PPO discounts.

This is a Pretreatment Estimate only and benefits will be determined at the time the claim is processed.
The patient must be eligible for benefits at the time of service.

Physician signature: Date:

Physician printed name: Phone number:

Address:

City: State: Zip: