OUT OF NETWORK – OUT OF POCKET CREDIT FORM for Premier Network EPO Bronze | Silver | Gold

Medical claims only - please complete one form per family member per provider.

Instructions

1. You will need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). It is recommended that you bring it with you to your appointment. Please also refer to the Help Sheet for additional information.
2. To request a credit to your out-of-pocket maximums, please submit the following to the address listed at the bottom of this form within six months from date of service† (any missing information may result in delay or denial of the request):
a. This completed and signed out of pocket credit form b. Proof of services rendered c. Proof of payment for the services being requested for credit d. Include itemized list of services
3. Most completed credit requests are processed within 45 days.
4. Credit will be applied to the plan member's out of pocket maximums once approved (see Help Sheet for definition) Contact Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)
5. Retain a copy of all receipts and documentation for your records.

Subscriber Information

Last Name:	First Name:	Middle Initial:

Patient Information

Patient's Ambetter Member ID#:	Last Name:	First Name:	Middle Initial:
Date of Birth (MM/DD/YYYY):		Telephone Number:	
Patient Email Address:		Does Patient have additional insurance? ☐Yes ☐No	Did other Insurance make a payment: ☐Yes ☐No **(If yes, include plan's EOB)**
Other Insurance Company Name:	Other Insurance Company Phone Number:	Other Insurance Policy Number:	

Provider & Service Information

(This section must be completed, and you will need your health care provider to assist in completing this section.)

Healthcare Provider's Name:	Healthcare Provider's NPI Number:	Healthcare Provider's Federal Tax ID #:	Healthcare Provider's Telephone Number:
Organization/ Group Name:	Organization/ Group NPI Number:	Organization/ Group Telephone Number:	Setting where treatment was received:
Healthcare Provider's Address:			
Did you contact your health plan to find an in-network provider before seeking care at an out-of-network provider?			

Diagnosis Codes	Diagnosis Description (e.g., flu, broken leg, manic-depressive disorder, asthma)	Date(s) of Service	Procedure Codes (for each service provided)*	Procedure Descriptions (e.g., x-ray, office visit, lab	Amount Paid
.		/ /			$
.		/ /			$
.		/ /			$
.		/ /			$
					$

† Six-month requirement will be waived if you or your covered dependent member had no legal capacity to submit such proof during that year.

Ambetter Member signature is required **Total Amount Paid**

Ambetter from Superior HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Superior HealthPlan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I attest that the above information is true and accurate and that the services were received and paid for as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims.

I also understand that Ambetter from Superior HealthPlan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name Signature Date

Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of service).
3. I have enclosed documents of Payment of Services (see the help sheet for an example of proof of payment).
4. I understand that most requests are processed within 45 days. Incomplete requests may take longer.
5. I attest that I am not on an **Ambetter Virtual Access or Value Plan** (or I attest that I am on a **Ambetter Premier** plan).

Please submit this form and all documentation to:

Ambetter from Superior HealthPlan • Attn: Advocate Out of Pocket Credit • P.O. Box 5010 Farmington, MO 63640-5010

OUT OF NETWORK – OUT OF POCKET CREDIT FORM - HELP SHEET / FAQs

Question	Answer
What is this form used for?	This form is used for EPO Bronze | Silver | Gold Network members to request credit for eligible medical care you have already received and made a payment directly to a provider, who will not file an insurance claim.
What is my responsibility?	Copayments, coinsurance, and non-covered services will be patient responsibility. If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible (i.e., balance billed) for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge. THIS IS NOT A GUARANTEE OF CREDIT. Actual credit for covered services will be paid at the appropriate level according to your plan benefits.
What happens next?	After processing your credit, you will receive an Explanations of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future. You may also refer to your member handbook on AmbetterHealth.com.
Who should I contact if I need help with completing this form?	Contact Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)
Field Name	**Description**
Subscriber Information	Subscriber is the person: Who enrolls in an Ambetter from Ambetter from Superior HealthPlan and signs the membership application form on behalf of him/ herself and any dependents. In whose name the premium is paid.
Patient's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetter from Superior HealthPlan Health Member ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's.
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting credit to apply against your coverage amounts.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

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