

Financial Estimate Worksheet

Use this worksheet as a guide to help you determine what costs you may incur when receiving services.

Μe	ember	r's Name: _										
												_
Me	ember	r's Address:										
the	e servi		ill be billing	g for y						dollar amour the services li		
We	e will o	also need th	ne followin	ng info	ormation:							
1.	Nam	ne of the pr	ovider and	d/or fo	acility who	ere the s	ervice will b	e rendered:				
		Provide	er ordering	g/renc	lering the	service:						
		Where	the servic	e will l	be done:							
2.	If at a	a facility, h	ow will it b	e dor	ne: [] c	out-patie	nt basis []	in-patient bo	asis			
3.		•						•				
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	To be	complete	d by Mem	ber/Pi	rovider		To be comp	oleted by The	e Health	n Plan Repres	entative	
Pro		Procedure Code	-		Billed	Allowed				Other	entative Total Member Cost	Prior
Pro	ovider	Procedure	Procedure		Billed	Allowed				Other	Total Member	Prior Aut
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Pro	ovider NPI *	Procedure Code	Procedure Modifier	Units	Billed Amount	Allowed	Deductible	Coinsurance	Copay	Other Member Responsibility	Total Member Cost	Prior Aut
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