Financial Estimate Worksheet

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

Member's Name: _____

The Health Plan ID #: _____

Member's Address: _____

Call the hospital and/or provider and ask that they supply you with the codes and dollar amounts for all the services they will be billing for your upcoming service/procedure. Please have the services listed in the appropriate boxes below.

We will also need the following information:

1. Name of the provider and/or facility where the service will be rendered:

   Provider ordering/rendering the service: _____

   Where the service will be done: _____

2. If at a facility, how will it be done: ☐ out-patient basis ☐ in-patient basis

3. Date the service will be provided: _____

To be completed by Member/Provider					**To be completed by The Health Plan Representative**						
Provider NPI	Procedure Code	Procedure Modifier	Units	Billed Amount	Allowed Amount	Deductible	Coinsurance	Copay	Other Member Responsibility	Total Member Cost	Prior Auth Require
****My Financial Responsibility**											

**** This is an estimate of the member's financial responsibility for benefits effective as of today. Facility and provider charges for services can vary from the types and amounts listed above, and the member's financial responsibility will vary accordingly. This worksheet is only a tool to estimate charges and financial responsibility and does not guarantee the amount The Health Plan will pay.**

How would you like us to return this information to you:

By fax, please give the fax number we are to use: _____

By mailing it to: _____