Estimation of Out-of-Pocket Expenses Form

FACILITY SERVICES | (WI ACT 146)

Please work with your health care provider to complete the required fields listed below. By providing the required information, a more complete "best estimate" of the customer/patient's out-of-pocket expenses can be given.

If Arise is not your primary insurer, please provide the Estimation of Out-of-Pocket Expenses from your primary carrier.

MEMBER INFORMATION	PROVIDER INFORMATION
Member Name:	Hospital Name:
Member Number:	Hospital Tax ID:
Member Group Number:	Hospital Billing Address:
Patient Name:	Hospital Servicing Address:
Patient Date of Birth:	Attending Physician Name:

SERVICE INFORMATION

Bill Type ______________ Discharge Status ______________

Revenue Codes	CPT/HCPCS Code	Modifiers	Units	Charges
			Total:	

Diagnosis Codes					
DRG Codes					
Principal Procedure Codes					

Please mail this completed form to:
Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

Disclaimer: A decision on payment can only be made when all necessary claim information is received and reviewed in accordance with all the provisions and limitations of the health policy/plan including, but not limited to: requirements for medical necessity, prior authorizations, pre-certifications, exclusions for work-related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage.

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