



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.