Written Estimate Request Form

You may request a written cost estimate for medical procedures and treatments. **You must complete this form in its entirety for an accurate estimate.** The information provided below will be used to calculate your written estimate, and we will respond to your estimate request within five business days of receipt of all necessary information.

Please note: Your estimate will be based solely on the information provided on this form.

Questions? Feel free to call us at **1-800-982-6257, ext. 11.**

Patient Information

All of the information in this form is required to initiate a request. This information, along with the provider-supplied details requested, will be used to calculate your written estimate.

Full name: _____

Member ID:_____

How would you like to receive your written estimate? (Please select one below).

☐ Email:_____

☐ Mail:_____

☐ Fax:_____

Service Provider Information

A provider could be a doctor, clinician, DME provider, audiologist, physical therapist, chiropractor, etc.

Provider full name: _____

Provider phone number:_____

Provider's NPI (National Provider Identifier), a ten-digit number used to identify the health care professional rendering the service (for billing purposes):_____

_____

1700 Magnavox Way, Suite 201 I Fort Wayne, IN 46804
Phone: 260-432-6690 I Toll Free: 1-800-982-6257
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Place of Service

For the most accurate estimate, verify with your provider whether the services will be performed in an office, facility, or other site. **Location of service has a significant impact on calculating your estimate.**

Facility information ☐ Inpatient ☐ Outpatient
(Check ONE): ☐ Office ☐ Surgery Center ☐ Hospital ☐ Lab/Radiology ☐ Other

Facility name:_____

Facility phone number:_____

Facility address (Street, City, State): _____

Facility NPI (National Provider Identifier), a ten-digit number used to identify the facility (for billing purposes):_____

_____

Service/Procedure and Diagnosis Code Information

Medical procedure or treatment description

Procedure(s) or treatment for which you are requesting an estimate *(example: I am requesting an estimate for a hip replacement)*:

_____

_____

Procedure codes are necessary for the treatment requested to get the most accurate estimate. For example: hip replacement may also include anesthesia, labs, X-rays, and other procedures.

Procedure codes (up to 10) to identify the treatment or services being performed. *i.e. Either CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes.*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Diagnosis codes (on per procedure, if available) to identify diagnosis. *i.e. ICD Code (International Classification of Disease).*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What to expect

Expect to receive your written estimate within five business days of receipt of a complete and accurate request by mail, secure email, or fax. Our normal business hours are 8 am - 5 pm (Eastern time). Please contact PHP Customer Service should you have any questions.

Physicians Health Plan of Northern Indiana
PO Box 2359
Fort Wayne, IN 46801
Fax: 260.969.2447
Email: custsvc@phpni.com

Please note: The estimate is based on the information provided. Final determination of benefits is made when a claim is received. If this information changes or should unforeseen services arise, the actual amount you will be responsible for may vary. If additional services or claims are received between the time an estimate is requested and the time the member receives the service, the level of benefits may also change.