COMMUNITY Health Options

Out of Network Lower Cost Provider Benefit Request Form

You may qualify to have your Out-of-Network expenses applied to your In-Network Deductible and Out-of-Pocket Maximum if:

- The price of the out-of-network provider is the same or less than the statewide average for the same covered health care service
- Your non-emergency, outpatient service falls within one of these service categories
  - Physical/Occupational Therapy
  - Laboratory Services
  - Radiology and Imaging Services
  - Infusion Therapy
  - Surgical Procedures
- Your service occurred within the past 90 days of this request

To determine the statewide average of a health care service, you will need to use comparemaine.org, a website maintained by the Maine Health Data Organization (MHDO). If you do not have access to the internet, the MHDO will provide the required information over the phone. Contact the MHDO at (207) 287-6722, Monday through Friday 8:30 a.m. to 5 p.m.

Follow the instructions on the tool to determine the lowest cost provider for your service. You may need to obtain more specific information about your service from your provider such as procedure description or procedure code.

Once you have determined the lowest cost provider for your service, you will need to elect to use that provider to perform the service.

Once you have decided to use the lowest cost provider, search our Provider Directory at **www.healthoptions.org/individuals-families/doctors-hospitals** to determine if they are in our network. If the provider is a member of our network, and any prior authorization requirements, if any, are met, then you need to do nothing further as the PPO Out of Network Lower Cost Provider benefit does not apply.

If the provider is not in our network and you choose to use the provider for your service, you may request that we apply your payment towards your In-Network Deductible and Out-of-Pocket maximums.

Please print, complete the form and submit it, along with all required documentation to:

Community Health Options
PO Box 1121
Lewiston, ME 04243

If you have any additional questions, please call Member Services at 1-855-624-6463.
Use this form to request that the Out-of-Pocket expense incurred when using a Lower Cost Out-of-Network Provider be applied towards your In-Network Deductible and Maximum Out-of-Pocket limits.

Please complete a separate form for each applicable service. If you have any questions on completing this form, please call Member Services at 1-855-624-6463.

Please complete the following information:

SUBSCRIBER INFORMATION			
Last Name	First Name	M.I.	Subscriber ID#
MEMBER (PATIENT) INFORMATION			
Last Name	First Name	M.I.	Date of Birth
			/ /
Mailing Address			Member ID #
City		State	Zip Code
PROVIDER INFORMATION			
Provider Name			Provider NPI
Group/Facility Tax ID #			Group/Facility NPI
Provider Street Address			City, State Zip

COMMUNITY Health Options

Provider Mailing Address (if different)	City, State Zip

CLAIM INFORMATION

Service Category

____ Physical/Occupational Therapy

____ Radiology and Imaging

____ Surgical Procedures

____ Infusion Therapy

____ Laboratory Services

Date of Service	Diagnosis Code	Procedure Code	Modifier	# of Units	Place of Service (POS)	Charge Amount	Paid Amount
/ /							
/ /							
/ /							
					Totals	$	$

ATTESTATION AND SIGNATURE

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Community Health Options may request any additional information it deems necessary to verity that services were received and/or payment was made.

Print Name	Member/Guardian Signature	Date
		/ /

Please attach the following information and submit it along with the Request Form:

- ☐ Copy of the Lowest Cost Provider information from https://www.comparemaine.org/.
- ☐ Copy of the provider's bill to you, including Date of Service, Service Provided, Amount Billed and Amount Paid
- ☐ Proof of your payment to the Provider

Please include your Name and Member ID# on all forms.

Submissions can be sent to:

Community Health Options
PO Box 1121
Lewiston, ME 04243

Community Health Options will process your request, or reach out to you for further information, within 30 days of receipt of all required documentation.