COMMUNITY Health Options®

# Out-of-Network Lower Cost Provider Benefits Request Form

## General Information

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 healthcare covered service
- Your non-emergency, outpatient service falls within one of these service categories
    - Physical or occupational therapy
    - Laboratory services
    - Radiology and imaging services
    - Infusion therapy
    - Surgical procedures
- Your service has occurred within the past 90 days of this request

## Initial Steps

To determine the statewide average of a healthcare service, please 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. Call MHDO at (207) 287-6722, from 8:30 a.m. to 5 p.m., Monday-Friday.

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 to determine if they are in our network. If the provider is a member of our network, and any Prior Approval 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.

## Instructions

Use this form to request that the out-of-pocket expense incurred when using a lower-cost out-of-network provider be applied toward your in-network deductible and maximum out-of-pocket limits. Please complete a separate form for each applicable service. If you have any questions, please call Member Services at (855) 624-6463.

Complete the form and submit it, along with all required documentation to:

Community Health Options
Mail Stop 200
PO Box 1121
Lewiston, ME 04243

COMMUNITY Health Options®

# Out-of-Network Lower Cost Provider Benefits Request Form

| Subscriber Information | | | |
|---|---|---|---|
| First Name | M.I. | Last Name | Subscriber ID # |
| | | | |

| Member (Patient) Information | | | | |
|---|---|---|---|---|
| First Name | M.I. | Last Name | Date of Birth | Member ID # |
| | | | | |
| Address | | City | State | Zip Code |
| | | | | |

| Provider Information | | | |
|---|---|---|---|
| Name | | Provider NPI | |
| | | | |
| Group/Facility Tax ID # | | Group/Facility NPI | |
| | | | |
| Street Address | City | State | Zip Code |
| | | | |
| Mailing Address (if different) | City | State | Zip Code |
| | | | |

## Claim Information

Please select the applicable service category:

- ☐ Physical or occupational therapy
- ☐ Surgical procedure
- ☐ Laboratory services
- ☐ Radiology and imaging
- ☐ Infusion therapy

| Date of Service | Diagnosis Code | Procedure Code | Modifier | # of Units | Place of Service | 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 canceled, and I may be subject to criminal and/or civil penalties for false healthcare claims. I also understand that Community Health Options may request any additional information it deems necessary to verify that services were received and/or payment was made. |
| Member's Signature _____ Print Name _____ 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 documents.

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

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