ConnectiCare

Medical Claim Pre-Estimate Form

Instructions

- Complete all fields on form and mail to ConnectiCare, Inc. 175 Scott Swamp Rd, Farmington, CT 06032 ATT: Claims Pre-Estimate or fax form to **860-409-2455**.
- All incomplete forms will be returned.

PATIENT / INSURED INFORMATION

INSURED'S NAME (Last Name, First Name, Middle Initial)	INSURED'S ADDRESS	
PATIENT'S ID NUMBER	PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	PATIENT'S DATE OF BIRTH / / MM DD YYYY	SEX ☐ M ☐ F

PROVIDER INFORMATION

PHYSICIAN'S FULL NAME	PHYSICIAN'S FEDERAL TAX ID NUMBER
PHYSICIAN'S ADDRESS	PHYSICIAN'S NPI #

MEDICAL SERVICE INFORMATION

Place Of Service	Revenue Code (only if outpatient facility)	Procedure (CPT/HCPCS Code)	Modifier	Diagnosis Code	Charge	Days Or Units

PRE-ESTIMATE RESPONSE INFORMATION

BELOW, PLEASE SELECT HOW YOU WOULD LIKE TO RECEIVE YOUR PRE-ESTIMATE RESPONSE.

U.S. mail to: _____

Email to: _____

Fax to: _____

*Please note:

- The cost information you will receive is a good faith estimate only and is not legally binding on ConnectiCare, Inc.
- This is a pre-estimate only and does not include any other services provided by other physicians or facilities (including but not limited to radiologists, pathologists, and anesthesiologists).
- The accuracy of the estimate that we provide you will depend largely on the specificity and accuracy of the information you provide to us regarding your proposed medical service.