

# OUT-OF-NETWORK CLAIM FORM

**DMC CARE - WSU**

**0826**

PATIENT INFORMATION (To Be Completed by Employee)				EMPLOYEE INFORMATION	
1. PATIENT'S NAME (First, middle initial, & last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME, ADDRESS, & PHONE NO.	
FULL-TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, where)				6. EMPLOYEE'S SOC. SEC. NO.	
4. PATIENT'S ADDRESS (If different from employee)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		8. FACILITY NAME	
9. IS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, give spouse's employer name & address)		7. PATIENT'S RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		12. IF AN ACCIDENT DATE ____ 20 ____ AND TIME ____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
10. ARE YOU, YOUR SPOUSE OR YOUR DEPENDENT CHILDREN ENTITLED TO BENEFITS UNDER A. ANY OTHER GROUP HEALTH OR WELFARE PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO B. MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		DESCRIPTION (HOW & WHERE)	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS REQUEST.  SIGNED _____ DATE _____				14. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE BELOW.  SIGNED (EMPLOYEE)	
PHYSICIAN OR SUPPLIER INFORMATION (Complete, fold, and mail)					
15. PATIENT'S NAME (First name, middle initial, last name)					
16. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		17. DATE FIRST CONSULTED YOU FOR THIS CONDITION		18. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>	
19. DATE PATIENT ABLE TO RETURN TO WORK		20. DATES OF TOTAL DISABILITY FROM _____ THRU _____		DATES OF PARTIAL DISABILITY FROM _____ THRU _____	
21. NAME OF INITIAL TREATING PHYSICIAN			22. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
23. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				24. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	
25. DIAGNOSIS OR NATURE OF ILLNESS/ INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1. 2. 3. ETC OR DX CODE 1. 2. 3. 4.					
26. A. DATE OF SERVICE	B. PLACE OF SERVICE*	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN Procedure Code (Identify ) (Explain unusual services or circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F.
27. SIGNATURE OF PHYSICIAN OR SUPPLIER  SIGNED _____ DATE _____		28. _____		29. TOTAL CHARGE	30. AMOUNT PAID
32. YOUR PATIENT'S ACCOUNT NO.		33. ENTER TAXPAYER IDENTIFICATION NO. TO BE USED FOR 1099 REPORTING PURPOSES:		31. BALANCE DUE	34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

**\*PLACE OF SERVICE**

- |                               |                                     |                                    |
|-------------------------------|-------------------------------------|------------------------------------|
| 1. (IH) - INPATIENT HOSPITAL  | 5. - DAY CARE FACILITY (PSY)        | 9. - AMBULANCE                     |
| 2. (OH) - OUTPATIENT HOSPITAL | 6. - NIGHT CARE FACILITY (PSY)      | 0. (OL) - OTHER LOCATIONS          |
| 3. (C) - DOCTOR'S OFFICE      | 7. (NH) - NURSING HOME              | A. (IL) - INDEPENDENT LABORATORY   |
| 4. (H) - PATIENT'S HOME       | 8. (SNF) - SKILLED NURSING FACILITY | B. - OTHER MEDICAL/SUPPLY FACILITY |

**\*NOTE TO DOCTOR**

If surgery is suggested, please sign and complete information below:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 6-74

Signature \_\_\_\_\_

Date \_\_\_\_\_

In my professional opinion, the surgery is elective  is not elective  and can  cannot  be performed at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

THIS FORM CAN BE USED FOR DMC CARE PPO OUT-OF-NETWORK MEDICAL, BH/SA, OR PHARMACY CLAIMS.

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**FOR OUT-OF-NETWORK MEDICAL CLAIMS**

**EMPLOYEES:**

1. You must complete this form for each different illness or accident. Fill out the top two sections (PATIENT INFORMATION & EMPLOYEE INFORMATION).
2. Attach an itemized receipt from the out-of-network medical provider.
3. If the out-of-network provider (physician, hospital, physical therapist, etc.) is billing directly, have the provider complete the claim form and return it to DMC CARE Claims Department.
4. Payments for services will be sent to the subscriber unless the provider is billing directly for services.
5. DMC CARE PPO members, please call (800) 543-0161 for further information.

**HEALTH CARE PROVIDERS:**

1. Complete the bottom portion of the form. Payment will be made directly to you unless your statement shows payment was made by the member. Hospitals use the UB-92 or your standard itemized billing form.
2. Providers can call (800) 543-0161 to verify eligibility and obtain authorization. Providers can call Weyco, Inc. at (800) 748-0003 to verify benefits coverage or claim inquiries.

MAIL ALL OUT-OF-NETWORK MEDICAL CLAIM FORMS AND ITEMIZED RECEIPTS TO:

WEYCO, INC.  
P. O. Box 30132  
LANSING, MI 48909-7632

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**FOR OUT-OF-NETWORK BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CLAIMS**

**EMPLOYEES:**

1. Fill out the top two sections (PATIENT INFORMATION & EMPLOYEE INFORMATION).
2. Attach an itemized receipt from the out-of-network provider.
3. If the out-of-network provider (physician, hospital, therapist, etc.) is billing directly, have the provider complete the claim form and return it to Value Options.
4. Payment for services will be sent to the subscriber unless the provider is billing directly for services.
5. DMC CARE PPO members, please call (877) 362-2472 (DMC-BHSA) for further information.

**HEALTH CARE PROVIDERS:**

1. Complete the bottom portion of the form. Payment will be made directly to you unless your statement shows payment was made by the member. Hospitals use the UB-92 or your standard itemized billing form.
2. Providers can call (877) 362-2472 (DMC-BHSA) to verify eligibility, benefits coverage, claim inquiries or obtain authorization.

MAIL ALL OUT-OF-NETWORK BEHAVIORAL HEALTH OR SUBSTANCE ABUSE CLAIMS TO:

VALUE OPTIONS  
ATTN: CLAIMS DEPARTMENT  
ONE TOWNE SQUARE, SUITE 600  
SOUTHFIELD, MI 48076

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**FOR OUT-OF-NETWORK PRESCRIPTION DRUG CLAIMS**

**EMPLOYEES:**

1. Fill out the top two sections (PATIENT INFORMATION & EMPLOYEE INFORMATION)
2. Attach an itemized receipt from the out-of-network pharmacy. The receipt must include the following information:
  - Pharmacy Name and Address
  - Member's Name
  - Prescription Dispensing Date
  - Units Dispensed
  - Drug Name
  - 11 digit National Drug Code (available from the pharmacist)
  - Days supplied
  - Amount Paid by DMC CARE Member
3. All payments for services will be sent directly to the employee.
4. Pharmacies or DMC CARE PPO members, please call (800) 837-9600 for further information.

MAIL ALL OUT-OF-NETWORK PRESCRIPTION DRUG CLAIM FORMS AND ITEMIZED RECEIPTS TO:

CLAIMSPRO  
24370 NORTHWESTERN HWY.  
SOUTHFIELD, MI 48075