surest®

Please review your responses below and **click the next button** at the bottom of the page to submit your claim.

If you would like to start over, click here to reset the form.

Surest out-of-network claim form

Complete this form and submit your claim(s) if you utilized a provider outside the Surest network.

Two quick questions:

Q: Is the out of network provider you used submitting claim(s) on your behalf?

YES: Great! We look forward to receiving it. (No further action is necessary.)

NO: Use this form to submit your claim(s).

Q: If you answered "No" above, do you have a copy of the out-of-network provider's bill?

YES: Be sure to include a copy (or copies) with this completed form.

NO: Contact the provider and ask for a copy of the receipt(s) and/or invoice. We'll need it to process this claim.

If the provider is outside the Surest network and in the United States:

1. Make sure the provider invoice includes:

- Patient name
- Date of service
- Place of service code
- Type of service
- Procedure codes (CPT, HCPC) with any applicable modifiers
- Billed amount for each procedure code
- Diagnosis codes
- Charges for each service (or total charges if bundled)
- Billing and/or rendering provider: first and last name and NPI, address information, provider's TIN, and the date

2. Attach your receipt(s) and/or invoice for the service or supply.
3. **Submit a separate form for each provider invoice.**

If the provider is outside the Surest network outside the United States:

1. Complete the form below.
2. Attach the itemized claim (in English) with the currency exchange rate for the date the services or supplies were received.
3. Attach medical records related to the claim.
4. Attach proof of payment to the provider for the services rendered.

Questions? Contact member services using the phone number on your ID card.

Thanks for choosing the Surest plan.

Subscriber's member ID number

123456789012

Subscriber name

First name	John
Middle initial	A
Last name	Doe

Subscriber date of birth
(MM/DD/YYYY)

01/01/1990

Subscriber group number

12345678

Subscriber employer name

ExampleCorp

Patient relationship to the subscriber

- ○ Self
- ○ Spouse or Domestic Partner
- ● **Dependent**

Member (Patient) name

First name: Jane

Middle initial: B

Last name: Smith

Member ID number

987654321098

Member date of birth
(MM/DD/YYYY)

02/02/1985

Member address

Please use the two-letter USPS state code in the State field

Street: 123 Main St Apt 101

City: Example City

State: NY

Zip Code: 12345

Did you receive services in a foreign country?

- ○ Yes
- ● **No**

Type of service

Medical Claim (All other types)

Place of service

Office (11)

Services and charges

Date of service (MM/DD/YYYY)	**Procedure, service or supplies code** Example: (E0601 / 97161). For birthing tubs enter L8699, for other home delivery supplies enter S8415. For breast pumps enter E0603 (electric breast pump) or E0602 (manual breast pump).	**Diagnosis code** Only enter the primary diagnosis code, example: (Z00.00). For lactating mother, enter Z39.1.
01/15/2024	E0601	Z00.00

Charges $
150.00

Do you have another service to add?

- ○ Yes
- ● **No**

Total Charge ($)	1200.00
Amount Paid ($)	0.00

Rendering Provider Information

Helpful tips:

1. If you have multiple provider invoices, you will need to submit a separate form for each one.
2. Please use the two-letter USPS state code in the State field.
3. Please ensure that the Federal Tax ID number (TIN) is 9 digits. If you don't have a Provider TIN, use 777777777.
4. If your claim is for Home Birth Supplies, enter 2024121800471 for Provider NPI. For Breast Pumps, enter 2024121800472. For Natural Cycles, enter 2022111401682. For Weight Watchers, enter 2020100900499. Otherwise, ensure the Provider NPI is 9 or 10 digits.

Provider Name	John Smith
Provider NPI	1234567890
Facility/Clinic Name (if available and different from the Provider Name)	
Federal Tax ID number (TIN)	777777777
Street Address	123 Medical Plaza
City	San Francisco
State	CA
Zip	94103

Attach receipt or invoice (Acceptable file types: .pdf or .jpg. Password-protected files are not accepted)

Make sure the provider invoice includes:

- Patient name
- Date of service
- Place of service code
- Type of service
- Procedure codes (CPT, HCPC) with any applicable modifiers
- Billed amount for each procedure code
- Diagnosis codes
- Charges for each service (or total charges if bundled)
- Billing and/or rendering provider: first and last name and NPI, address information, provider's TIN, and the date

Invoice.pdf

0.5 MB

application/pdf

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Want to start over? Click here to reset the form.

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