surest
A UnitedHealthcare Company

bind is now Surest.
Same great health plan. New name.

Surest
P.O. Box 211758
Eagan, MN 55121

Surest out-of-network claim form

Complete this form and submit your claim(s) if you utilized a provider outside of 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 sbumit your claim(s).

Q: If you answered "No" on the left, 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's invoice includes:
   - Patient name
   - Date of service
   - Place of service code
   - Type of service
   - Procedure codes (CPT, HCPC) with any applicable modifiers
   - Units for each procedure code
   - 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 signature, and the date.
2. Attach your receipt(s) and/or invoice for the service or supply.
3. Submit a separate copy of this form for each provider and each type of service and procedure code.

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

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

Mail the completed form with your receipt(s) and/or invoice to:

Surest
P.O. Box 211758
Eagan, MN 55121

Payer: Surest
Payer ID: 25463

Questions?
Contact Surest Member Services at 1-866-683-6440.

Thanks for choosing the Surest plan.

Surest out-of-network claim form

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Member (Patient) name (Last name, first name, middle initial)		**Member ID number**	
Member birth date (MM/DD/YYYY)		**Member sex**	☐ M ☐ F
Member relationship to subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other		
Member address	STREET		
	CITY	STATE	ZIP
Member phone number			

Subscriber name (Last name, first name, middle initial)			
Subscriber policy or group number (Last name, first name, middle initial)		**Employer's name**	

Patient or authorized person's signature: I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED	DATE (MM/DD/YYYY)

Subscriber's or authorized person's signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED	DATE (MM/DD/YYYY)

Accept assigment? ☐ Yes ☐ No

Date(s) of service From MM	DD	YY	To MM	DD	YY	**Place of service**	**Type of service**	**Procedures, services or supplies** (Explain unusual circumstances) CPT/HCPCS		Modifier	**Diagnosis code**	**Charges**	
											TOTAL CHARGE		
											AMOUNT PAID		

Signature of provider or supplier, including degrees or credentials: I certify that the statements on this form apply to this bill and are made a part thereof.

SIGNED	DATE (MM/DD/YYYY)

Facility where services were rendered	RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) #	NPI TYPE	☐ NPI Type 1 (for an individual)	☐ NPI Type 2 (for an organization)
	FACILITY NAME		PHONE	
	FEDERAL TAX ID NUMBER	☐ SSN ☐ EIN		
	RENDERING PROVIDER NAME			
	STREET ADDRESS	CITY	STATE	ZIP

Billing information	BILLING NATIONAL PROVIDER IDENTIFIER (NPI) #	NPI TYPE	☐ NPI Type 1 (for an individual)	☐ NPI Type 2 (for an organization)
	BILLING NAME		PHONE	
	STREET ADDRESS	CITY	STATE	ZIP

▶ **Member signature:** I certify that the information provided on this form is correct to the best of my knowledge.

SIGNED	DATE (MM/DD/YYYY)