MEDICAL COST ESTIMATE CLAIM FORM

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LEAD TOGETHER

1. A fully completed form facilitiates its processing.
2. Complete a separate form for each patient and for each occurance.
3. Return this form prior to admission to: claims@breckpoint.com or Fax: 1.888.622.3033

CLAIM TYPE	☐ Medical ☐ Dental ☐ Vision ☐ Rideshare Transportation

PRIMARY MEMBER INFORMATION		PATIENT INFORMATION	
Member ID Number:	Group Number:	Relationship to Primary Member *(check applicable box)* ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	
Name *(Last,First, Middle Initial, Suffix)*	Date of Birth *(MM/DD/YYYY)*	Name *(Last,First, Middle Initial, Suffix)*	Date of Birth *(MM/DD/YYYY)*
Address *(Street, City, Stat, Zip)*		Address *(Street, City, Stat, Zip)*	

Documentation for each request will need to show **date of service, description of service provided and charges,** as well as the **provider's name and address**.

- Please itemize your cost estimate request to help facilitate proper processing. If you have more expenses than this form allows, please attach an additional form. If you do not itemize your expenses, we will process your cost estimate claim based on the documentation received.
- Participants must have Cost Estimates submitted within 90 days after the date of service.
- For questions, please call: **844-798-4878**

RECORD OF SERVICE PROVIDED

(A) EXPECTED PROCEDURE DATE *(MM/DD/YYYY)*	(B) Procedure Code or Description of Service	(C) Diagnostic Code or Description	(D) Providers Name *(Last Name, First Initial)*	(E) Quantity	(F) Patient Responsibility *(Filled out by the Claims Department)*
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

PROVIDER INFORMATION

Name:	
Address *(Street, City, Stat, Zip)*	
Telephone Number	Tax ID Number

Certification and Release of Information:

I, as the undersigned, certify that the information on this Cost Estimate Form is true and correct to the best of my knowledge. I expressly authorize the release of any medical, health or other personal information necessary to process this Cost Estimate I certify that I am a participant in the company's Plan corresponding with the member ID and group number identified above and that all expenses for which Cost Estimator by submission of this form will be incurred during the period while I am covered under the Plan. I represent and warrant that I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this Cost Estimate, and that unless an expense for which the Cost Estimate is claimed as a proper expense under the Plan, I may be liable for payment of all amounts (including taxes) which relate to such expense.

Signature of Insured Member: Date: