Use this form:
• If you are seeking reimbursement for a medical service that you received within the last 6 months (180 days) and paid for out of your own pocket.
• If you are requesting payment to be made to an out-of-plan or nonparticipating provider from which you received a medical service.
• If you are requesting coordination of benefits with your primary insurance company.

1. You must enclose the original itemized bill from your provider. An itemized bill must include the following information: date of service, diagnosis (cause and nature of a person’s illness), procedure code (description of the procedure), place of service (office visit, hospital, ambulatory surgery center, etc.) charges and payments made; and the provider’s full name, address, phone number and provider tax ID number/and or National Provider Identifier (NPI).

   • A balance due statement from your provider is not acceptable and your claim cannot be processed.

   • If services were rendered outside of the United States, please provide an itemized bill written in English which shows the amount paid in U.S. dollars.

   • If coordination of benefits is being sought, attach a copy of the primary carrier’s Explanation of Benefits along with the itemized bill.

   • To expedite payment of your claim, please be sure that your providers tax ID number is on the itemized bill. If the tax ID number is not on the bill, please obtain the number and write it on the bill you are enclosing.

2. Complete the entire form on the reverse side.

   • Please use one claim form for each claim you are submitting.

3. Mail the complete form and attachments indicated above to:

   **Medical and Surgical Claims**
   ConnectiCare Claims Department
   P.O. Box 546
   Farmington, CT 06034-0546

   **Mental Health and Substance Abuse Claims**
   OptumHealth Behavioral Solutions
   P.O. Box 30757
   Salt Lake City, UT 84130-0757

Retain a copy of your claim submission for your own records.
Out-of-Plan Reimbursement Form

(Please print or type)

1. PATIENT’S NAME
   (Last Name, First Name, Middle Initial)

2. PATIENT’S ID #

3. PATIENT’S ADDRESS
   No., Street
   City State
   ZIP Telephone Number

4. PATIENT’S STATUS
   □ Single  □ Married  □ Other  □ Employed  □ Full-Time Student  □ Part-Time Student

5. PATIENT’S BIRTHDATE
   SEX □ Male  □ Female
   MM DD YY

6. PATIENT’S RELATIONSHIP TO INSURED
   □ Self  □ Spouse  □ Child  □ Other

7. IS PATIENT’S CONDITION RELATED TO:
   ACCIDENT AT WORK?  □ Yes  □ No
   AUTO ACCIDENT?  □ Yes  □ No
   OTHER ACCIDENT?  □ Yes  □ No
   ILLNESS?  □ Yes  □ No
   DID CONDITION OCCUR WHILE?
   □ ON VACATION  □ AWAY AT SCHOOL  □ OTHER _________________________________

8. INSURED’S NAME
   (Last Name, First Name, Middle Initial)

9. INSURED’S ADDRESS
   No., Street
   City State
   ZIP Telephone Number

10. INSURED’S GROUP NUMBER/GROUP NAME (See ID Card)
    a. INSURED’S ID NUMBER (SEE ID CARD)
    b. IS INSURED COVERED UNDER ANOTHER HEALTH BENEFIT PLAN?
       □ Yes  □ No
       If yes, complete item 11 a-d
    c. INSURED’S DATE OF BIRTH
       SEX □ Male  □ Female
       MM DD YY

11. OTHER INSURED’S NAME (See ID Card)
    a. OTHER INSURED’S POLICY OR GROUP INFORMATION
       Group # ___________________________________
       Patient ID# ________________________________
       Insurance Co. Name __________________________
    b. OTHER INSURED’S DATE OF BIRTH
       SEX □ Male  □ Female
       MM DD YY
    c. EMPLOYER’S NAME OR SCHOOL NAME
       _____________________________________________
    d. INSURANCE PLAN NAME
       OR PROGRAM NAME
       _____________________________________________

12. SHOULD PAYMENT BE MADE TO:
    SELF  □ Yes  □ No
    PROVIDER  □ Yes  □ No
    If yes, please sign item #14

13. DESCRIBE CONDITION OR ILLNESS:
    _____________________________________________
    _____________________________________________
    WHERE WERE SERVICES RENDERED?
    □ Urgent Care Ctr  □ Hospital  □ Office
    _____________________________________________
    _____________________________________________

14. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE:
    I authorize payment of medical benefits to the physician or supplier indicated on the attached
    original itemized bill for services.
    SIGNED __________________________________________________________________________________

15. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE:
    I authorize the release of any medical or other information necessary to process this claim. I certify that the information provided is correct to the best of my knowledge and belief. Any person who, knowingly and with intent to defraud any MCO or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of committing a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. If you suspect fraud, call ConnectiCare’s Special Investigative Unit at 1-800-349-2833.
    SIGNED DATE ____________________________________________________________________________
Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 1-800-833-8134. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


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