Cost Estimate Request

- This form is for UCare Choices and Fairview UCare Choices plan members only.
- The exact amount UCare will pay will be determined when we receive the claim from your provider.

To be completed by member: Please provide complete information.

Member name ____ **Date of birth**________________ **UCare ID#**______________

Please provide the specific surgery, procedure or service to be estimated: ____________________________________

____

Where should we mail your estimate? Street _____________________________________ **Apt/Suite #** _____________

City________________________________ **State** _________ **Zip code** _______________

Provider*: Please list all service or product components to ensure a more accurate cost estimate.*

Provider Name ____ **Provider#** _______________**NPI#**________

	Charge	CPT code	Modifier 1 or 2	Anticipated date of service	Place of service code	Diagnosis code	Unit of service	Individual practitioner#
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
		← TOTAL						

When complete, please submit this form:

- by **fax** to: 612-676-6810
- by **email** to: costestimate@ucare.org
- by **mail** to: UCare, 500 Stinson Blvd. NE, Minneapolis, MN 55413