

**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 submit 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 were 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**

**surest**™

<b>Member (Patient) name</b> (Last name, first name, middle initial)		<b>Member ID number</b>	
<b>Member birth date</b> (MM/DD/YYYY)		<b>Member sex</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Member relationship to subscriber</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
<b>Member address</b>	STREET		
	CITY	STATE	ZIP
<b>Member phone number</b>			

<b>Subscriber name</b> (Last name, first name, middle initial)	
<b>Subscriber policy or group number</b> (Last name, first name, middle initial)	<b>Employer's name</b>

**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)

**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)

<b>Facility where services were rendered</b>	RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) #	NPI TYPE	<input type="checkbox"/> NPI Type 1 (for an individual) <input type="checkbox"/> NPI Type 2 (for an organization)
	FACILITY NAME		PHONE
	FEDERAL TAX ID NUMBER		<input type="checkbox"/> SSN <input type="checkbox"/> EIN
	RENDERING PROVIDER NAME		
	STREET ADDRESS	CITY	STATE

<b>Billing information</b>	BILLING NATIONAL PROVIDER IDENTIFIER (NPI) #	NPI TYPE	<input type="checkbox"/> NPI Type 1 (for an individual)	<input type="checkbox"/> 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)
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