WEA trust

Estimation of Out-of-Pocket Expenses

(WI ACT 146):

At the written request of our members, WEA Trust will provide a good faith estimate of the reimbursement that WEA Trust will expect to pay and the member's responsibility (out-of-pocket costs) for a specified health care service that is being considered. Note: This process does not take the place of a prior authorization, prior approval, or precertification.

Please be aware that pre-service estimates provided are not a guarantee of payment and are not legally binding. Actual payment will be based on the terms, conditions, and provisions of the policy/plan and will be subject to the usual and customary or contracted rates that are in effect at the time the service is performed, including, but not limited to: requirements for medical necessity, prior authorizations, precertifications, exclusions for work-related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage. Also, the estimate of out-of-pocket expenses will be prepared and based on information submitted to us, along with current claims and benefits we have processed at the time of our response to the inquiry, and will assume no modifications or complications occur in the treatment plan.

45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

Estimation of Out-of-Pocket Expenses Form

PROFESSIONAL SERVICES (WI ACT 146)

Please work with your healthcare provider to complete the required fields listed below. By providing the required information, a more complete "best estimate" of the member/patient's out-of-pocket expenses can be given.

If WEA Trust is not your primary insurer, please provide the Estimation of Out-of-Pocket Expenses from your primary carrier.

MEMBER INFORMATION	PROVIDER INFORMATION
Member's Name:	Clinic Name:
Member's Number:	Clinic's Tax ID: and Clinic's NPI:
Member's Group Number:	Clinic's Billing Address:
Patient's Name:	Clinic's Servicing Address:
Patient's Date of Birth:	Servicing Provider's Name:
	Referring Provider's Name:

SERVICE INFORMATION

Procedure Codes	Modifiers	Date of Service	Units	Place of Service	Diagnosis Code	Charges
					Total:	

Please return this completed form to:
WEA Trust
PO Box 21538
Eagan MN 55121

Disclaimer: A decision on payment can only be made when all necessary claim information is received and reviewed accordance with all the provisions and limitations of the health policy/plan including, but not limited to: requirements for medical necessity, prior authorizations, pre-certifications, exclusions for work-related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage.

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FACILITY SERVICES (WI ACT 146)

Please work with your healthcare provider to complete the required fields listed below. By providing the required information a more complete "best estimate" of the member/patient's out-of-pocket expenses can be given.

If WEA Trust is not your primary insurer, please provide the Estimation of Out-of-Pocket Expenses from your primary carrier.

MEMBER INFORMATION	PROVIDER INFORMATION
Member's Name:	Hospital Name:
Member's Number:	Hospital Tax ID: and Hospital NPI:
Member's Group Number:	Hospital Billing Address:
Patient's Name:	Hospital Servicing Address:
Patient's Date of Birth:	Attending Physician's Name:

SERVICE INFORMATION

Bill Type __________ Discharge Status __________

Revenue Codes	CPT/HCPCS Code	Modifiers	Units	Charges

Total: __________

Diagnosis Codes					
DRG Codes					
Principal Procedure Codes					

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Eagan MN 55121

Disclaimer: A decision on payment can only be made when all necessary claim information is received and reviewed in accordance with all the provisions and limitations of the health policy/plan including, but not limited to: requirements for medical necessity, prior authorizations, pre-certifications, exclusions for work-related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage.