(DT 616)

Cost Estimate Request

Name of Requester: _____

Phone Number: _____

Email Address: _____

Date(s) of Service: _____

Duration of rendered service: _____

Member Name: _____

Member ID Number: _____

Group Number: _____

Provider Name: _____

Tax ID: _____

Billing NPI: _____

Professional:

Diagnosis Code: _____

Place of Service: _____

Unit/Minute count if necessary for the service provided: _____

	Service Code	Modifier	Primary Diagnosis	Charged Amount
1				
2				
3				
4				
5				
*If additional service codes are being requested, please complete an additional form.				

Institutional:

Type of Bill: _____

Admit Diagnosis: _____

Unit/Minute count if necessary for the service provided: _____

Revenue Code: _____

IMPORTANT NOTICE: This determination does not guarantee benefits or payment of services. Please allow 30 days for this request to be completed. A letter will be generated with details once processed. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact Avera Health Plans Customer Care team at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

If you have questions, please contact Avera Health Plans Customer Care at 605-322-4545 or toll-free at 1-888-322-2115.

Fax this completed form to Avera Health Plans at 605-322-4540 or send secure email to Service@AveraHealthPlans.com.