



# Determination of Benefits Worksheet

Use this worksheet as a guide to help you determine what costs you may incur when receiving services.

Member Name: \_\_\_\_\_

Subscriber Number: \_\_\_\_\_

Member Address: \_\_\_\_\_

Call the clinic and/or facility and ask that they supply you with an itemized listing of the services they will be billing during your visit. This list should include the date of service, CPT (Procedure), DRG, HCPCS Codes and the charge for each code. Record that information in the chart below.

At what facility will the procedure or treatment take place? (check one)

- Primary Care Provider's (PCP office)
- At a hospital on an in-patient basis (Be sure to ask for applicable DRG codes)
- At a hospital on an out-patient basis
- Other – Please list: \_\_\_\_\_

Fax this completed form to Unity's Benefits Team at 608-644-2040.

We will provide you with an estimate of the amount Unity will reimburse and your member liability.

We will do our best to respond to requests within 48 business hours.

**Date of Service:** \_\_\_\_\_

TO BE COMPLETED BY UNITY

Billing / Provider NPI	Procedure Billing Code	Procedure Modifier	Units	Billed Amount	Allowed Amount	Deductible	Coinsurance	Copay	Other Member Liability	Total Member Liability	Prior Authorization Required
<b>My Financial Responsibility **</b>											

*\*\*This is an estimate of the member's financial responsibility for benefits effective as of today. Facility and provider charges for services can vary from the types and amounts listed, and the member's financial responsibility will vary accordingly. This worksheet is only a tool to estimate charges and financial responsibility and does not guarantee the amount Unity Health Insurance will pay.*

How would you like us to respond back to you? (circle one):      FAX                              MAIL

Provide contact details (fax number or mailing address): \_\_\_\_\_  
 \_\_\_\_\_