



Surest
P.O. Box 211758
Eagan, MN 55121

Surest claim form

Complete this form and submit your claim(s) on your own.

Two quick questions:

Q: Is the provider you used submitting your claim(s) on your behalf?

YES. Great! We look forward to receiving it.
(No further action is necessary.)

NO. Please use this form to submit your claim(s).

Q: If you answered “No” on the left, do you have a copy of the 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(s). We’ll need it to process this claim.

Note: If the claim is for an in-network provider, we are contractually obligated to send claim payments to the provider.

If the provider is in the United States:

- 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.
- Attach your receipt(s) and/or invoice for the service or supply.
- Submit a separate copy of this form for each provider and each type of service and procedure code.

If the provider is outside the United States:

- Complete the form on the other side of this page.
- Attach the itemized claim (in English) with the currency exchange rate for the date the services or supplies were received.
- Attach medical records related to the claim.
- Attach proof of payment to the provider for the services rendered.

If you’re submitting for doula services:

- Please use the codes below for procedure/service and diagnosis code.
- If payment was bundled for multiple services, include this amount as “total charged.”

Type of service	CPT/HCPCS code	Diagnosis code
Prenatal visit	S9445	Z33.1
Labor & delivery visit	99199	N/A
Postnatal visit	S9445	Z39.2

If you’re submitting for electrolysis for gender dysphoria:

- Please use the codes below for procedure/service and diagnosis code.
- All gender dysphoria treatments require prior authorization. All procedure codes require one of the diagnosis codes below to be prior authorized:

Type of service	CPT/HCPCS code	Diagnosis code
Electrolysis epilation, each 30 minutes	17380	F64.0, F64.1, F64.2, F64.8, F64.9, or Z87.890

Mail the completed form with your receipt(s) and/or invoice:

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 claim form



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

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

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)
--------	----------------------

Accept assignment? Yes No

Date(s) of service						Place of service	Type of service	Procedures, services or supplies (Explain unusual circumstances)			Diagnosis code	Charges
From			To					CPT/HCPCS	Modifier			
MM	DD	YY	MM	DD	YY							
TOTAL CHARGE												
AMOUNT PAID												

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)
--------	----------------------

Facility where services were rendered	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

Billing information	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

Member signature: I certify that the information provided on this form is correct to the best of my knowledge.

SIGNED	DATE (MM/DD/YYYY)
--------	----------------------

Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates. Insurance coverage provided by UnitedHealthcare Benefits Plan of California. Administrative services provided by United HealthCare Services, Inc. or its affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates, including United HealthCare Service LLC in NY. Stop-loss insurance underwritten by UnitedHealthcare Insurance Company or its affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY. All Fully Insured Plans in California: If medically appropriate care from a qualified provider cannot be provided within the Network, we will arrange for the required care with an available and accessible out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider. Surest Fully Insured Plans in California: A complete Network and timely access to care may only be available by obtaining treatment through providers available at the maximum Copayment shown for each service at the lowest cost-sharing tier. While some network providers are available at lower Copayments (reduced cost-sharing rates), there is no guarantee of a complete Network or timely access to care at any specific reduced cost-sharing rate. © Bind Benefits, Inc., d/b/a Surest. All rights reserved. B2B2C_25-AI-1236408_0325