

**Surest**  
**P.O. Box 211758**  
**Eagan, MN 55121**

## Surest claim form

Fill out this form to submit a claim on your own.

### Two quick questions:

**Q:** Is the 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).

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

**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. We’ll need it to process this claim.

### If the provider is 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 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?

Member Services is available online via chat and email or by calling the number on the back of your Surest member ID card.



**Thanks for choosing the Surest plan.**

**Surest claim form**

<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 gender</b>	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Other
<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>		<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)
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**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)
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**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						
<b>TOTAL CHARGE</b>											
<b>AMOUNT PAID</b>											

**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)
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<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

**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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