Pre-Treatment Estimate Request Form

Please use this form to request an estimated allowable charge for a medical service or procedure. The allowable charge is the maximum amount a provider can be paid for your service or procedure. Depending on your medical benefits, you may be responsible for paying a portion of this amount through deductibles, coinsurance, or copayments, and FIC may be responsible for paying a portion of this amount.

Many out-of-network providers will accept the allowable charge as payment, but in some cases, the provider will bill you for the balance between the allowable charge and the provider’s actual charge. If this occurs, you are responsible for the full amount billed above the allowable charge, which can be a significant expense.

There are two ways you can request an allowable charge estimate:

1. If your doctor or hospital is in-network, you may contact them directly for an estimate. If they are unwilling to provide an estimate, you can request one from FIC by following the instructions below.
2. If your doctor or hospital is out-of-network, you can request an estimate from FIC by following the instructions below.

To receive an estimate from FIC, please complete the following steps:

1. Fill out all fields completely in the attached form. You’ll need to contact your provider or provider’s billing office for certain information, such as your specific diagnosis code, the service or supply CPT code, and the provider’s tax ID.

2. Sign the completed form and mail or fax it to FIC at:
   Freelancers Insurance Company
   P.O. Box 84224
   Seattle, WA 98124
   Fax: 800.437.8441

3. If you require allowable charge estimates for multiple services or procedures from multiple providers, you’ll need to submit a separate form for each provider. If multiple services are being requested from a single provider, one form is acceptable.

4. Once you submit your form, you’ll usually receive confirmation within one business day that your form has been received.

5. You’ll usually receive the allowable charge estimate within 10 business days.
Here are a few important things to keep in mind about your allowable charge estimate:

- Your provider may perform and bill for additional services that aren’t included in the estimate, which would result in a change in cost.
- The nature of your service or procedure may change while in progress, which would result in a change in cost.
- Changes in industry standards that determine the price of certain services may result in a change in cost.
- Any recent negotiations between your provider and the Blue Card PPO® network, including any changes in your doctor’s or hospital’s network status, may result in a change in cost. This means that once you or your doctor submit the claim, the network will price the claim based on the provider’s current contract and FIC will determine benefits based on that priced claim. Benefits are not determined based on the estimated prices.
- The estimate includes only the service or procedure you indicate in your request. Additional charges may be billed by other doctors, hospitals, and facilities that may be related to the service or procedure. For example, if your doctor performs your surgery in a hospital, you may be billed separately for other doctors’ services who were involved in the surgery (such as an anesthesiologist) and the hospital’s charges.
- If you do not include all of the information requested in the attached form, it may impact the accuracy of the estimated costs for your services.

If you have any questions, please contact us at 800.707.8802.
# PRE-TREATMENT ESTIMATE REQUEST

Please complete this form in its entirety. If you do not include all of the information requested below, it may impact the accuracy of the estimated costs for your services.

## MEMBER INFORMATION

<table>
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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Medical ID # (Listed on your FIC ID card)</th>
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<td>FGN_____________________________</td>
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## PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Provider Full Name (Please circle one: Physician Facility)</th>
<th>Provider’s Tax ID #</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City/State</th>
<th>Zip Code</th>
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<tr>
<th>Provider’s EPIN #</th>
<th>Provider’s NPI #</th>
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## TREATMENT/SERVICE/SUPPLY INFORMATION (Your provider can give you the information below.)

- **ICD-9 (Diagnosis) Code(s):**
- **CPT (Procedure) Code(s) – Please include any and all applicable modifiers:**
- **For DME or Supplies, HCPCS Code(s):**

## ACKNOWLEDGEMENT/DISCLAIMER: PLEASE READ CAREFULLY

The Allowable Request Service (“the Service”) is provided by FIC as a courtesy to its Members. The prices quoted through the Service are estimates. FIC does not guarantee that these will be the exact prices charged to its members by healthcare provider or allowed by FIC at the time the claim is processed. Actual prices may differ from estimated prices for a number of reasons, including but not limited to changes in provider contracts, if applicable; change in industry benchmarks that determine the price of certain services; the receipt of non-covered services by the Member (such as private room in a hospital); or the performance of additional or different procedures by the provider than those for which estimates were provided. The quotation of an estimated price through the Service does not constitute, and should not be interpreted as, a determination by FIC that a particular service or procedure is medically necessary or is covered under a particular FIC plan. In addition, this Service does not satisfy any pre-certification requirements that your plan may require for these estimated services.

While FIC makes all reasonable efforts to provide this Service in a timely manner, FIC relies on third parties to deliver the Service and cannot guarantee that estimated prices will be provided within a specific time period in each instance. Members should not delay necessary, time-sensitive medical care due to delays in the operation of the Service.

I hereby authorize that I have read the above disclaimer, and understand all stipulations contained therein.

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<tr>
<th>Signature: __________________________________________</th>
<th>Date ___ / ___ / ________</th>
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<tr>
<td>Print Name: __________________________________________</td>
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