



## Cost Estimate Request

- This form is for UCare Individual & Family Plans and UCare Individual & Family Plans with Fairview members only.
- We'll send your estimate to the address you provide below within 10 business days from the day we receive your completed form.
- The exact amount UCare will pay will be determined when we receive the claim from your provider.

To be completed by member: Please provide complete information.

Member name \_\_\_\_\_ Date of birth \_\_\_\_\_ UCare ID# \_\_\_\_\_

Please provide the specific surgery, procedure or service to be estimated: \_\_\_\_\_

Where should we mail your estimate? Street \_\_\_\_\_ Apt/Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Provider:** Please list all service or product components to ensure a more accurate cost estimate.

Provider Name \_\_\_\_\_ Provider# \_\_\_\_\_ NPI# \_\_\_\_\_

	Charge	CPT code	Modifier 1 or 2	Anticipated date of service	Place of service code	Diagnosis code	Unit of service	Individual practitioner#
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
		← TOTAL						

When complete, please submit this form:

- by fax to: 612-884-2485
- by email to: [costestimate@ucare.org](mailto:costestimate@ucare.org)
- by mail to: UCare, 500 Stinson Blvd. NE, Minneapolis, MN 55413