Blue Cross and Blue Shield of Minnesota and Blue Plus

P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000

Dear member:

You requested a cost estimate from Blue Cross and Blue Shield of Minnesota or Blue Plus that explains what your health plan will pay for a health care service at a specific provider. Please follow the steps below so that we may process your estimate.

To obtain your health care cost estimate

1. Ask your hospital to complete the Request for Cost Estimate Hospital and Other Facility Services form on the back of this letter. You can also ask your provider to download forms from **providers.bluecrossmn.com** and then "forms & publications."
2. This form must be filled out completely in order for a cost estimate to be processed.
3. Once your provider has completed the form, either you or your provider can return it to Blue Cross at the fax number or mailing address on the form.
4. Blue Cross will process your request within 10 business days of receiving the completed cost estimate form.

Only an estimate

Please note that the cost information you will receive is a good faith estimate only and is not legally binding on Blue Cross. The exact amount your health plan will pay can't be determined until we receive a claim from the provider and process it.

Other health cost resources available

Online tools with general information about the cost of health care services are also available to you. Simply sign in to the online member center, myBlueCross, at **members.bluecrossmn.com** (or the web address on the back of your member ID card). If you haven't already done so, you'll need to register before entering this website. Both of the tools below are found using the "choosing care" tab, then, "see all cost & quality resources,"

- **Average medical cost estimate:** See average costs for over 70 common medical conditions and procedures.
- **Care Comparison®:** Find estimated costs and quality information for dozens of common medical procedures performed at hospitals, imaging centers or outpatient surgery centers.

If you have questions, please call Customer Service at the number on the back of your member ID card.

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-8000** (voice), or **1-800-382-2000** (toll free).

For TTY: Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 7 a.m. to 8 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.

Sincerely,

Customer Service
X16333R06 (1/15)

bluecrossmn.com

BlueCross BlueShield Minnesota

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REQUEST FOR COST ESTIMATE
HOSPITAL AND OTHER FACILITY SERVICES

MEMBER: Use this form for cost estimates for services to be received at facilities including hospitals, home health care agencies, home, skilled nursing facilities and outpatient surgical centers. Please fill out this section and ask your provider to complete the rest of the form. This form must be filled out completely in order for a cost estimate to be processed.

Member Name _____ Member Phone_____
(First and Last)

Patient Name_____ Patient Birth Date _____
(First and Last)

Identification Number _____ Group Number _____
(shown on member ID card)

Anticipated Service _____
(i.e. tonsillectomy, adenoidectomy, bunionectomy, cataract surgery)

PROVIDER: Please complete all sections below with best-available information. If no date is indicated BCBSM will base its estimate on the date the estimate is processed.

Blue Cross and Blue Shield of Minnesota Provider Number_____ NPI# _____

Type of Bill _____ Place of Service _____ Admission Type _____

Anticipated Admitting/Registered Diagnosis_____

Anticipated Other Diagnosis _____ _____ _____ _____ _____ _____ _____

Anticipated Date of Service _____ Anticipated Patient Discharge Status_____

Anticipated ICD Surgical Code* _____ _____ _____

Occurrence Code* _____ Date _____ Occurrence Code*_____ Date _____

Occurrence Code *_____ Date _____ Condition Code* _____

Revenue Code	Units of Service Per Day	Charge	CPT/HCPC* Code	Modifier* 1	2

Total Charge _____

_____
(First and Last name)

Contact's Phone Number _____ Date Completed _____

Please return form:

fax: 651-662-2745 - OR

mail: Blue Cross and Blue Shield of Minnesota
Incoming Service Center
P.O. Box 64560
St. Paul, MN 55164-0560