Determination of Benefits Worksheet

Use this worksheet as a guide to help you determine what costs you may incur when receiving services.

Member Name: _____

Member Number: _____

Member Address: _____

Call the clinic and/or facility and ask that they supply you with an itemized list of the services they will be billing during your visit. This list should include the date of service; Current Procedural Terminology (CPT); Diagnosis Related Group (DRG); Health Common Procedure Coding System (HCPCS); International Classification of Diseases, Tenth Revision (ICD-10); and the charge for each code. Record that information in the chart below.

At what facility will the procedure or treatment take place? (check one)

☐ Primary care provider's office (PCP).

☐ At a hospital on an inpatient basis. Be sure to ask for applicable DRG codes.

☐ At a hospital on an outpatient basis.

☐ Other – Please list: _____

Fax this completed form to the Customer Success Team at (608) 644-3544.
We will provide you with an estimate of the amount Quartz will reimburse and your participant liability.
We will respond to requests within 24 business hours.

Date of Service: _____

TO BE COMPLETED BY PROVIDER					TO BE COMPLETED BY QUARTZ						
Provider Name/ Location Name	Procedure Billing Code	Procedure Modifier	Units	Billed Amount	Allowed Amount	Deductible	Coinsurance	Copay	Other Participant Liability	Total Participant Liability	Prior Authorization Required
My Financial Responsibility *											

* *This is an estimate of the member's financial responsibility for benefits effective as of today. Facility and provider charges for services can vary from the types, and amounts listed and the member's financial responsibility will vary accordingly. This worksheet is only a tool to estimate charges and financial responsibility, and does not guarantee the amount Quartz will pay.*

How would you like us to respond back to you? (check one): ☐ Fax ☐ Mail ☐ MyChart

Provide contact details (fax number or mailing address): _____

_____

_____