The Alliance
Self-Funding Smart®

Cost Estimate Request Form

Thank you for requesting a cost estimate before your upcoming procedure. Different provider locations can charge different prices for the same procedure. Knowing what a procedure may cost at a particular location, puts you on the path to becoming a better health care consumer.

Step 1: To be completed by Alliance Member.

Name of Alliance Member: _____

Date of Birth: _____

Member I.D. #: _____

Home Zip Code: _____

Email Address: _____

(Circle one)
Yes **No** I want to see the cost estimate for the procedure(s) listed below at additional in-network providers in my area.

If yes, how far away from home (miles or metro area) are you willing to travel for service? _____

Step 2: Give this form to your doctor's office to complete this section. They may refer you to their billing office or a different department to obtain this information.

Place of Service	CPT and Modifiers	Total Charge	Units

Date services will be performed: _____

Check all other services that apply: ☐ Anesthesia ☐ Radiology ☐ Lab/Pathology ☐ In-Patient Stay ☐ Surgery Center

Step 3: Alliance Member must read and sign.

I understand that the information to be provided by The Alliance is an estimate of costs and is intended to be used for budgeting purposes only. I further understand that this is not a pre-authorization, a guarantee of coverage or payment for services if provided.

Patient Signature: _____ Date: _____

Step 4: Send the completed form to The Alliance by one of the following methods.

Fax: 608.210.6677 **Email:** csr@the-alliance.org **Mail:** The Alliance; P.O. Box 44365; Madison, WI 53744-4365