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 healthcare consumer.

To be completed by The Alliance Member.

Name of The Alliance Member: ____________________

Date of Birth: ____________________ Member I.D. #: ____________________

Home Zip Code: ____________________ Email Address: ____________________

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

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

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.

Name of The Alliance Member: ____________________

Date of Birth: ____________________ Member I.D. #: ____________________

Home Zip Code: ____________________ Email Address: ____________________

Date services will be performed: ____________________

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

The 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: ____________

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

Learn more at
the-alliance.org | 800.223.4139 | info@the-alliance.org

The Alliance
Self-Funding Smart®