Direct Bill Request Form

Please complete all fields below so that we can request direct billing for your medical services from a non-contracted medical provider on your behalf. Please note that although we may request direct billing, the medical care providers are under no obligation to comply with our request and you may still be required to pay for your services up front, and submit your claim to the insurer for reimbursement providers.

A. INSURED PERSON INFORMATION (PATIENT)	
Name (Last, First, MI):	
Policy #:	Member ID #:
Employer (if applicable):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Email:	
Describe Medical Services you are having performed at this facility (Ex: Outpatient Consultation, Maternity/delivery, Physical Exam, etc.):	
If you will receive a non-emergency treatment at the hospital (for anything other than normal or C-Section delivery of a baby), having a surgical procedure using general anesthesia, or having other services requiring Pre-authorization as listed in your policy booklet, you must complete the Pre-authorization Form and receive written authorization from TieCare Assist prior to obtaining those services. The claim may be denied or a penalty of 50% of the claim may be applied with failure to obtain Pre-authorization from TieCare Assist in advance.	
B. PROVIDER INFORMATION	
Provider/Facility/Hospital Name:	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	
PROVIDER/FACILITY/HOSPITAL CONTACT PERSON	
Name:	
Phone:	Email:
TREATING PHYSICIAN	
Name:	
Phone:	Email:

C. INSURED AUTHORIZATION	
Name:	Date:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	

Please send the completed Direct Bill Request Form to directbill@tiecare.com.