REQUEST FOR OUT OF NETWORK PRICE

This form is to be used by providers who do not have contracted rates with Alliant Health Plans. By submitting this form the provider is requesting the Maximum Allowable Cost (MAC) price for Out of Network (OON) services.

Date: _____ MM/DD/YYYY

Practice Name: _____ Facility Name: _____

Tax ID: _____ Provider NPI: _____

Provider Name: _____ Service Location Address: _____

Phone Number: _____ Provider Contact: _____

Fax Number: _____ Email Address: _____

Type of Claim (please circle): CMS 1500 or UB04

Procedure (Include CPT, HCPCS and/or Revenue codes)	**Units**	**Provider Charge**	**Alliant Health Plans MAC Price** (To be completed by Alliant)

Please note: This is not a guarantee of payment. Benefits will be determined upon receipt of claim and will be based on, but not limited to, the member's eligibility and the terms of the member's plan benefits applicable on the date the service is rendered.

Return this form to:
Alliant Health Plans | ATTN: Provider Relations
Email: providerrelations@AlliantPlans.com
Fax: (706) 529-4275