



Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway — P.O. Box 8190 — Madison, WI 53708-8190



THE EPIC LIFE INSURANCE COMPANY
1765 W. Broadway — P.O. Box 8430 — Madison, WI 53708-8430

Estimation of Out of Pocket Expenses Form – Facility Services (WI ACT 146)

Please work with your provider to complete the required fields listed below. By providing the required information a more complete “best estimate” of the customer/patient’s out of pocket expenses can be given.

If WPS is not your primary insurer, please provide the Estimation of Out of Pocket Expenses from your primary carrier.

Member Information:

Member Name: _____
Member Number: _____
Member Group Number: _____
Patient Name: _____
Patient Date of Birth: _____

Provider Information:

Hospital Name: _____
Hospital Tax ID: _____
Hospital Billing Address:

Hospital Servicing Address:

Attending Physician Name:

Service Information:

Bill Type: _____ Discharge Status: _____

Revenue Code(s)	CPT/HCPCS Code	Modifier(s)	Unit(s)	Charge(s)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total:

Diagnosis Codes: _____, _____, _____, _____, _____



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DRG Codes: _____, _____, _____, _____, _____

Principal Procedure Codes: _____, _____, _____, _____, _____

Please send this completed form to:

WPS
Attn: Customer Service
1717 W. Broadway
P.O. Box 8190
Madison, WI. 53708

Or Fax to the Attention of Customer Service at: (608) – 223 - 3626

Disclaimer: A decision on payment can only be made when all necessary claim information is received and reviewed in accordance with all the provisions and limitations of the health policy/plan including, but not limited to: requirements for medical necessity, pre-authorizations, pre-certifications, exclusions for pre-existing illness and/or work related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage.