AT&T CarePlus Procedure Form
To be used for Out of Network Care and Treatment

AT&T CarePlus – A Supplemental Medical Program is an optional supplemental medical program designed to cover expenses for certain approved procedures not covered under the patient's medical program. The purpose of this form is to Pre-Certify Covered Procedures or for a retrospective approval of a designated Emergency Covered Procedure through AT&T CarePlus. To receive benefits from the Program, you must be actively enrolled in CarePlus and treatment must be pre-approved in writing by the CarePlus Coordinator, with the exception of a designated Emergency Covered Procedure. To receive 100% benefit coverage, you must use an Approved Facility for treatment.

Along with your physician thoroughly complete the following information for coverage consideration.

Patient Information			
Patient's Last Name	First	Middle	Relationship:
Patient's Mailing Address	City	State/Zip Code	Home Phone No.
Please indicate primary insurance	UNITEDHealthcare ☐	Other ☐	Please specify
Member Information			
Member's Last Name	First	Middle	Member ID:
Street Address	City	State/Zip Code	Home Phone No.
Fax No.			
TO BE COMPLETED BY ORDERING PHYSICIAN – Basis for Request			
Specific Medical Services being requested. Please include diagnosis codes. Please refer to CarePlus Covered procedures in the Program's Summary Plan Description (link above) for eligible procedures.			
Description of Specific Medical Service to be provided. Please include *medical records, notes, treatment program, and prognosis, CPT and/or HCPC codes, where available/applicable.*			
Physician's Name/Signature:			Phone No.
Physician's Mailing Address	City	State/Zip Code	Fax No.
Facility Name(where medical services to be performed):			United Health Care Network Participant ☐ Yes ☐ No
Facility Mailing Address	City	State/Zip Code	Phone/Fax No.
Facility Contact Name: (Patient Access Coordinator):			Phone/Fax No.

A complete list of procedures and requirements can be found in your CarePlus SPD or SMM (Summary of Material Modification. You may access these documents using the Quick Links tile at https://careplus.att.com.

Mail or fax completed form and all supporting documentation to:

Mail to:
AT&T CarePlus Program
PO Box 30886
Salt Lake City, UT 84130

OR:

Fax to:
(888) 369-0957

AT&T CAREPLUS Out of Network (OON) FACILITY QUESTIONNAIRE

Facility Name where treatment will take place:_____

Facility Address: _____

City, State Zip Code: _____

Facility Phone #: _____

Facility Contact Person:_____

Is the proposed facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO and/or by the Healthcare Facilities Accreditation Program (HFAP)?
[ ] Yes [ ] No If yes, please provide copy of accreditation.

Is the facility appropriately licensed by all necessary/required regulatory bodies?
[ ] Yes [ ] No If yes, please provide licensure documentation.

Is the physician administering the investigational treatment board-certified in the relevant specialty by a member board of the American Board of Medical Specialties?
[ ] Yes [ ] No If yes, please provide Board Certification Certificate.

If this is related to a clinical trial, is the treatment being administered in accordance with protocols consistent with those utilized by the National Cancer Institute, as articulated in "The Programming and Execution of a Clinical Trial" section of its Handbook?
[ ] Yes [ ] No

Completed by: Date:

_____ _____
Name and Title

Please return completed questionnaire to:

CarePlus Coordinator
AT&T CarePlus Program
PO Box 30886
Salt Lake City, UT 84130