Fax Request To: **1-855-374-0833;**
ATTN PwC Out of Network Pricing Requests

Out Of Network Pricing Request Form

For Use By PwC Partners, Staff and Retirees Enrolled In A UnitedHealthcare Medical Plan Option

Date:_____

NAME:_____ ADDRESS 1:_____

MEMBER ID #: _____ADDRESS 2: _____

MEMBER DAYTIME PHONE#: _____CITY, STATE ZIP: _____

MEMBER EMAIL ADDRESS: _____

We will email a response to you within 2-3 business days after receiving your request, however depending on the level of complexity, additional time may be needed for completion. If you would like a representative to call you back as soon as the information is completed, check the box here ☐

If the amount a non-network provider charges exceeds the Eligible Expense allowed by UnitedHealthcare, you are responsible for 100% of these charges.

Provider Name:_____

Provider Full Address: _____

Provider Telephone Number: _____

Provider Tax ID (if available): _____

Expected date of procedure: _____

Obtain from Provider

CPT Code: _____

CPT Code: _____

CPT Code: _____

CPT Code: _____

Diagnosis Code: _____

Charge (if known): _____

UnitedHealthcare to Provide

Estimated Eligible Expense: _____

Estimated Eligible Expense: _____

Estimated Eligible Expense: _____

Estimated Eligible Expense: _____

Diagnosis Code: _____

Note:

- A response to this request does not indicate a guarantee of benefits; this is a pricing estimate only to assist you in determining future out of pocket expenses. This does not represent a coverage determination.
- The cost estimates provided here are based on the known costs of the procedures you selected at the time we completed the pricing request. Other factors may impact the actual costs at the time services are rendered.
- The pricing provided are estimates only and you should not consider them to be a guarantee of actual costs at the time you receive services or a guarantee of payment.

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