PCL Construction
REQUEST FOR APPEAL OF OUT OF NETWORK PROVIDER FORM
Balance Billing of charges above 140% of MNRP

Plan Member Info

Plan Member Name: ________________________ Insurance Card ID Number: _________________

Plan Member Home Address: ____

Plan Member Work Address: ____

Provider Information

Provider Name and Credentials: ______________________ Phone: __________________________

Address, City, State, Zip: ____

Where Services Took Place (if different from above): __________________________________

Miles from home/work address: ____

Claim Information:

Date(s) of Service: ____

Patient Name: ______________________ Patient Date of Birth: _______________

Patient Relation to Plan Member: ____

Circumstances for using Out of Network Provider (i.e. emergency, no provider within 30 miles of home/work location, secondary type provider):
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____
____
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Type of Out of Network Provider Service:

- ☐ Ambulance
- ☐ Anesthesiologist
- ☐ Emergency Room Physician
- ☐ Medical Services (no providers within 30 miles of work or home zip code)
- ☐ Radiology
- ☐ Pathology / Laboratory services

Required:

1. Provider's Billing statement
2. Copy of Medical Explanation of Benefits

Plan Member Signature: ______________________ **Date: ________________________________**

REIMBURSEMENT SUBMITTAL PROCESS:
Submit this PCL Construction Appeal Form with required attachments, to PCL Construction's Third Party Administrator within 30 days of receiving provider's billing statement.

The address is:
UMR
Attn: Theresa James / PCL Construction Team
20021 120th Ave. NE STE. 200
Bothell, WA 98011.

Fax Number is 1-855-536-0488

Please allow 14 business days for claims to process before calling customer service at 1-800-826-9781.

UMR
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