REASONABLE AND CUSTOMARY PRE-TREATMENT ESTIMATE FORM

TO: MUTUAL MEDICAL PLANS, INC.
1025 COMMERCE BANK BLDG.
PEORIA, IL 61602
ATTN: CAROL R. JONES

Phone No. 309-674-0888
FAX No. 309-674-5420

RE: _____
Employee Name

_____
Employee Plan I.D. letter & number

Physician Name & Address: _____

_____

_____

Patient Name: _____

Diagnosis: _____

Surgical Procedure (s): _____

CPT Code: _____ FEE: _____ R&C Allowed _____

CPT Code: _____ FEE: _____ R&C Allowed _____

CPT Code: _____ FEE: _____ R&C Allowed _____

If more than one procedure, are they to be done together? _____

Hospital Name & Address: _____

_____

Surgery Date: _____ Inpatient? _____ Outpatient? _____

Mutual Medical Comments: _____

_____

_____

_____

PLEASE NOTE THAT THIS IS AN ESTIMATE ONLY. ALL SERVICES WILL BE SUBJECT TO THE LIMITS AND EXCLUSIONS OF THE PLAN THAT APPLIES TO THIS MEMBER AND/OR PATIENT.