CENTRACARE Health

PRICE ESTIMATE REQUEST

NAME: _____
(First) (Middle) (Last)

ADDRESS: _____
(Number and Street Name) (City) (State) (Zip)

TELEPHONE: _____ DATE OF BIRTH: _____

INSURANCE COMPANY: _____

GROUP#: _____ MEMBER#: _____

PROCEDURE OR SERVICE FOR PRICE ESTIMATE (INCLUDE ANY KNOWN PROCEDURE CODES): _____

_____

_____

PHYSICIAN/PROVIDER FOR PROCEDURE/SERVICE: _____

CENTRACARE HEALTH SITE OF SERVICE (NAME OF FACILITY AND CITY): _____

DATE OF PROCEDURE/SERVICE: _____ PROCEDURE/SERVICE IS NOT SCHEDULED: _____

PREFERRED METHOD OF RESPONSE:

- ☐ RETURN PHONE CALL
- ☐ RETURN PHONE CALL, OKAY TO LEAVE MESSAGE OF ESTIMATE
- ☐ MAIL

PLEASE EMAIL, FAX, SCAN, OR MAIL THE COMPLETED FORM.

You may complete this form electronically or you may print it and return the completed form.

Submit Completed Form

Submit

Scan and Email: PatientPriceEstimatesHospital@centracare.com
Fax: 320-656-7009
Mail: CentraCare Health
Attn: Managed Care
1406 6th Ave N
St. Cloud, MN 56303

Please allow 24 – 48 hours for response. If you have questions or need immediate assistance, please call 320-251-2700 ext. 53129 or 800-961-3589 ext. 53129.