Out-of-Area Benefits for Dependents

Providence Health Plan offers an Out-of-Area benefit for Dependent Members **(please refer to your Member Handbook for "Dependent" and "Out-of-Area Dependent" definitions and eligibility requirements)**. Enrolled Out-of-Area Dependents are eligible to receive routine care and other covered benefits while in or out of the service area. When enrolled as an Out-of-Area Dependent, coverage is as stated on the Out-of-Area Dependent Summary of Benefits and based on the Usual, Customary and Reasonable (UCR) charges for both in and out-of-area services. Amounts charged in excess of UCR are the responsibility of the member if the service is provided by a non-participating provider. **Status changes are effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.**

Enrolled Out-of-Area Dependents are responsible for obtaining prior authorization from the Plan prior to receiving certain services from non-participating providers. For further information about prior authorization, including a list of these covered services and how to obtain prior authorization, please refer to your Member Handbook.

When utilizing emergency services, Providence Health Plan must be notified within 48 hours or as soon as reasonably possible.

To obtain coverage for your Out-of-Area Dependent, fill out the Out-of-Area Dependent Enrollment Form below and mail it to **Providence Health Plan, PO Box 4327, Portland, OR 97208-4327.**

KEEP TOP HALF FOR YOUR RECORDS

FOR HEALTH PLAN USE ONLY

RP = DE
MS = OA

Providence Health Plan

Out-of-Area Dependent Enrollment Form

MAIL TO:
PROVIDENCE HEALTH PLAN
P.O. Box 4327
Portland, OR 97208-4327

Benefits for Out-of-Area Dependent Members are effective the date you specify below, or if no date is specified, on the first of the month following our receipt of this enrollment form. Retroactive changes are limited to 30 days. Please complete this form and return it to Providence Health Plan as soon as possible.

Employer Name Tech Solutions Inc. Group No. TS54321

Subscriber's Name Jane M. Smith

Subscriber's Address _____

City _____ State _____ Zip _____ Member I.D No. PH987654321

1. Dependent's Name Michael T. Smith Dependent's Birthdate 08/15/2006

   Dependent's Address 123 University Ave

   City Boulder State CO Zip 80309 Member I.D. No. _____

2. Dependent's Name _____ Dependent's Birthdate _____

   Dependent's Address _____

   City _____ State _____ Zip _____ Member I.D. No. _____

Requested effective date if different from first of the month following our receipt of this form: _____

PLEASE PRINT, SIGN AND DATE IN SPACE BELOW

SUBSCRIBER'S SIGNATURE _____ DATE _____