Upper Peninsula Health Plan

Subject: **Exception to Payment**

Date: _____

The Upper Peninsula Health Plan member below *DOES NOT* have primary insurance coverage for services rendered.

Please Print Clearly.

1. **Member Name:**_____
2. **Member ID #:** _____
3. **Provider Office:** _____

   Provider Name: _____

   Address: _____

   City, State, Zip: _____

   Verified by: _____
4. **Primary Insurance Information**

   Medicare Other (Please Circle)

   Primary Insurance Name: _____**Effective Date:** _____

   Primary Insurance Phone Number: _____

   Primary Insurance Policy Number: _____

   Primary Insurance Point of Contact for Verification: _____
5. **The services listed below are not a covered benefit by the Primary Insurance listed above.**

   Service(s): _____

   CPT-4/HCPCS/MUPC: _____

   Date of Service: _____
6. **I do not have other health insurance.**

   _____ _____

   (Member's Signature) **(Effective Date)**
7. **This form was completed by:** _____

- **Attach this verification to the CMS 1500 or UB-04 form for processing.**
- **All sections of this form must be completed; indicate N/A if something is not applicable.**

► **This form is *NOT* to be mailed to UPHP members for completion.** ◄